

July 2014



- I. Executive Summary**
- II. Background and Introduction**
- III. Analysis of Current SC DDSN Funding and Reimbursement Practices**
 - a. Funding for Services**
 - b. Provider Billing**
 - c. Medicaid Cost Reporting**
- IV. Analysis of Current SC DDSN Program Oversight**
 - a. Existing Data Resources (CDSS, ANE)**
 - b. Licensing and Quality Control**
 - c. Direct Care Staffing**
 - d. Ranking of South Carolina's Program Compared to Other States**
- V. Recommendations for SC DDSN Business Practices**
- VI. Appendix**
 - a. Table A: LAC audit recommendations categorized into 22 subjects**
 - b. Table B: Broad range of critical incidents that are required to be reported**

I. Executive Summary

Background

The South Carolina Department of Disabilities and Special Needs (SC DDSN) was established under South Carolina Code of Laws §44-20-240 and given authority over all of the state's services and programs for the treatment and training of persons with intellectual disability, related disabilities, head injuries, and spinal cord injuries.¹ South Carolina Code of Laws §44-20-250 further establishes the powers and duties of SC DDSN to include the coordination of services and programs with other state agencies and local agencies, contracting and negotiating with local agencies, county DSN boards, and private organizations to provide a full range of services to those individuals for whom the Department is responsible.²

In May 2013, SC DDSN engaged Public Consulting Group (PCG) to conduct a review of their business practices with a focus on their practices related to the funding and reimbursement of services and in providing program oversight. As part of this engagement PCG met with the leadership of SC DDSN to gain an understanding of the current practices as well as those areas that have been identified as the core functions of the Department. PCG also reviewed prior reviews and audits of SC DDSN including those conducted by the SC Legislative Audit Council (LAC), the SC Department of Health and Human Services (SC DHHS), and the US Department of Health and Human Services, Office of the Inspector General (OIG) to identify those areas within SC DDSN that have been subject to the scrutiny of external entities and how SC DDSN has responded to those reviews. Lastly PCG interviewed some of the numerous stakeholders in the SC DDSN system including staff at four providers representing a cross-section of the SC DDSN provider network, staff at one DDSN regional center, representatives from Alliant, the vendor contracted by SC DDSN, and CMS approved QIO, to provide quality assurance and licensing support, and staff from SC DHHS.

Overview of the Report

PCG's report focused on two of the core functions and responsibilities of SC DDSN; the funding and reimbursement for services provided to consumers in the SC DDSN system and program oversight, including SC DDSN data and systems integrity and SC DDSN oversight and assurances with regards to quality of direct care staffing, particularly in the residential setting(s). Through the review of these core functions of SC DDSN, PCG also reviewed the structure within which SC DDSN and their provider network operate, the Organized Health Care Delivery System (OHCDS).

Analysis of Current SC DDSN Funding and Reimbursement Practices

The responsibilities of SC DDSN related to the funding of and payment for services provided to SC DDSN consumers encompass a wide range of activities from the funding of the DSN Boards to ensure access to services across the state to serving as a clearinghouse for all provider reporting of activities and Medicaid cost reporting. PCG reviewed three of the core activities of SC DDSN

¹ South Carolina Code of Laws §44-20-240. <http://www.scstatehouse.gov/code/t44c020.php>

² South Carolina Code of Laws §44-20-250. <http://www.scstatehouse.gov/code/t44c020.php>

related to funding and reimbursement practices; funding for services, provider billing, and Medicaid cost reporting. In reviewing SC DDSN's practices related to the funding of services, PCG looked specifically at the funding band approach used to ensure all available funds, including state general revenue funds and Medicaid funds, are allocated to the DSN Boards across the state in a consistent and equitable manner. Through the review of the funding bands, which is furnished prior to the services being rendered, and the fee-for-service reimbursement approach, which occurs following the provision of the services, PCG found that while there is some inconsistency in the manner in which the DSN Boards and the private, QPL providers are reimbursed, it is driven by the need for SC DDSN to ensure that the DSN Boards have the necessary funding to provide the full continuum of services in all parts of the state. Conversely the QPL providers, who as contractors have the ability to determine which populations they serve, what services they provide, and where they provide those services, receive their reimbursement only for the actual services they provide. PCG also found that one of the main points of confusion surrounding the funding bands is that they are commonly cited as a reimbursement mechanism when in fact they are truly a funding mechanism, similar to those used by state agencies operating state hospitals or intermediate care facilities.

In the review of the provider payment processes, in which the providers report their service activity to SC DDSN and SC DDSN submits the claims for the Medicaid eligible clients, PCG found that the DSN Boards and the QPL providers benefit from SC DDSN's role in the system. In serving as a 'clearinghouse' through which all service activity is submitted and claims generated for submission to Medicaid, SC DDSN is performing many functions on behalf of the providers that help to minimize the amount of overhead costs incurred by the providers while also minimizing the risk of improper claiming by ensuring that the claims submitted to SC DHHS are compliant with Medicaid regulations. Further, in the event of an audit by SC DHHS, SC DDSN assumes responsibility for responding to the audit and any findings. Lastly, PCG's review of the Department's Medicaid cost reporting process was found to be compliant with state and federal reporting requirements. PCG did however, note that the current process requires significant manual effort for the providers and the state staff. This is a process that PCG believes would be significantly enhanced through the development of a web-based, automated cost reporting tool that more clearly leads staff through the cost reporting process while also building in many of the audit checks, accumulation of data, and calculations that are currently done manually.

Analysis of Current SC DDSN Program Oversight

PCG's review of SC DDSN's current efforts related to program oversight similarly focused on some of the core functions performed by the Department. The review first looked at the existing data resources used by the Department in managing their system. This included the systems in place for critical incident reporting, abuse and neglect (ANE) reporting, and finally other provider reporting requirements. PCG's review then focused on the Department's efforts related to licensing and quality control; two activities where SC DDSN has partnered with external entities in the Department of Health and Environmental Control (DHEC) and Alliant. Lastly, PCG reviewed the Department's policies for and oversight of the direct care staff across the various provider settings.

PCG also reviewed South Carolina's performance relative to other states based on the 2014 United Cerebral Palsy's (UCP) annual scorecard called the "Case for Inclusion". This annual UCP publication ranks how well state Medicaid programs serve persons with intellectual and developmental disabilities across five main indicators and summarizes the score into one overall ranking. South Carolina's ranked sixth best in the nation. It is hard for states to rank high on these state scorecard projects and it means that South Carolina has a better program than other states.³ In comparing South Carolina's performance relative to its peers in the southeast, only Georgia ranked higher at number four with Louisiana being the next highest at number twelve. Notable rankings for other southeastern states include North Carolina ranking 24th, Virginia 49th and Mississippi ranking last at 51st. South Carolina's performance is even more impressive relative to its southeastern peers given the unique features of South Carolina's system when compared to others. For example, Georgia's rise to number four was driven largely by its closure of three, large state institutions, an option not readily available to South Carolina given the number of individuals served in the state's four regional centers that could not reasonably be served in a community based setting.

Through the review of SC DDSN's current practices and of national indicators, PCG found that SC DDSN has undertaken considerable effort in establishing processes, data systems, and relationships with external entities to provide quality care for the state's most vulnerable citizens.

Recommendations for SC DDSN Business Practices

Following the completion of PCG's review of the current funding and reimbursement and program oversight practices of SC DDSN PCG developed a set of recommendations for the Department to consider in their effort to continually improve their system. The following list of recommendations do not cite any major areas of concern for the SC DDSN system but rather highlight those areas and processes within the current system that could be enhanced to further improve the care provided to those individuals for whom SC DDSN is responsible.

1) SC DDSN should consider a move from the OHCDS model to a more current model

While PCG did not uncover any major concerns with the OHCDS model under which SC DDSN currently operates, the Department has been the target of recent criticism of the OHCDS model. In conducting a scan of the health care industry there are few systems operating under a similar OHCDS model. With a trend away from the historical OHCDS model towards new, integrated health care models encompassing multiple disciplines like physical and behavioral health care as evidenced by the growth in medical or health homes and other like models, PCG believes SC DDSN could benefit from a more in depth review of the existing OHCDS model and some of the more current models available to the Department. In addition to the considerations for the integrated care models like the medical or health homes, SC DDSN

³ See <http://cfi2014.ucp.org/wp-content/uploads/2014/03/Case-for-Inclusion-2014.pdf>

could consider models that include increased integrated employment opportunities or housing initiatives with state and/or federal housing authorities. In recommending that SC DDSN consider a shift from the OHCDS model to a more current model, PCG is not recommending that SC DDSN change its role in many of the vital functions it currently fills today including, but not limited to, setting program policy and establishing funding mechanisms for community based providers.

- 2) *SC DDSN should continue to pilot the use of a national needs assessment tool and consider a future alignment of the Funding Bands with the national needs assessment tool*

SC DDSN has already begun a limited pilot program to utilize the American Association on Intellectual and Developmental Disabilities (AAIDD) Supports Intensity Scale (SIS) as part of its needs assessment process. PCG believes the use of this tool is an important step for SC DDSN and encourages the Department to continue its plan to expand its use statewide. While this tool is not currently linked to funding resources, PCG recommends that SC DDSN consider aligning funding resources with the SIS in the future. PCG believes that SC DDSN, by aligning the funding bands with the SIS tool, could more accurately align funding with the individual needs of the consumers. PCG recommends that SC DDSN continue to expand its use of the SIS as an assessment tool statewide before considering the recommendation to align funding resources with this tool.

- 3) *SC DDSN should enhance the documentation for Cost Reporting Policies and Procedures*

SC DDSN's documentation of the policies and procedures for cost reporting, and in particular, the process for collecting and auditing the individual cost reports of the community providers and for subsequently compiling this data in to the single cost report for the Department could be enhanced to improve the transparency of this process for both internal and external stakeholders. SC DDSN has greatly improved its documentation and transparency around many of its processes, including its cost report processes as evidenced by the development of Department Directives such as 250-10-DD, Funding for Services; 250-05-DD, Cost Principles for Contracts and Grants with Community Providers; 275-04-DD, Procedures for Implementation of SCDDSN Provider Audit Policy; and 250-09-DD, Calculation of Room and Board for Non-ICF/ID Programs. PCG believes SC DDSN could further enhance its documentation and transparency by developing similar documents that clearly explain the processes completed by SC DDSN staff in reviewing and aggregating the cost report data from each of the individual providers as well as the process to incorporate this data in to the Department's cost report that is ultimately submitted to SC DHHS.

- 4) *SC DDSN should move towards automating the Medicaid Cost Reporting process*

The current Medicaid cost reporting process is largely based on Microsoft Excel based cost reporting forms with Department staff responsible for compiling all of the individual provider reports and transferring the aggregate data to the single Department cost report. An automated cost report process would allow for a more efficient process through built in audit checks and the ability to aggregate the multiple provider cost reports in to the single cost report. SC DDSN

would have many options to consider in moving to an automated cost report solution and would be able to work with a vendor to develop a system that is designed to address the unique needs of SC DDSN as opposed to trying to adapt an off the shelf solution.

5) *SC DDSN should separate service coordination and service delivery*

The current system in which providers can serve as both the service coordination and the service provider raises concerns over the conflict of the service coordinator referring services to be the benefit of the provider and not in the best interest of the consumer. This recommendation would see a phased-in move towards the separation of service coordination from service delivery. This recommendation would also serve to bring SC DDSN closer to the current preferences of CMS.

6) *SC DDSN should continue moving towards more frequent licensing visits and changes in visit protocol*

PCG's recommendation for moving towards more frequent licensing visits for all residential settings is a continuation of the recent changes by SC DDSN from licensing visits every three years to every two years. The Department is currently conducting annual licensing visits for day programs, respite and child residential settings and PCG believes annual licensing visits would help to further improve the quality of care for the SC DDSN consumers. In the 2008 review of SC DDSN the LAC cites a study by the University of South Carolina, School of Public Health that found that no other state conducted licensing reviews of facilities on a less than annual basis. It should however be noted that the study did not discuss the level of detail in which these reviews were conducted and whether they were inclusive of both licensure and quality assurance or just licensure reviews, making it difficult to truly compare the practices of SC DDSN with those of other states.

Additionally, PCG believes that changes to site visit protocols such as requiring provider management to not be present during the visit would help to increase the independence of the reviews. It is PCG's opinion that the presence of management during the entirety of the site visits inhibits the freedom of expression of the staff and as a result excludes information that may be pertinent to the evaluation of quality.

7) *SC DDSN should continue to educate stakeholders and prepare for changes in federal quality standards*

PCG recommends that SC DDSN staff continue to monitor, educate stakeholders and prepare the potential changes in quality management coming from the federal government, including changes in how quality is addressed in 1915(c) applications for federal waivers. CMS has been actively working with representatives from a number of national associations, including NAMD, NASDDDS, and NASUAD to review the Continuous Quality Improvement System process that states must incorporate in their 1915(c) HCBS waiver applications. PCG notes that SC DDSN State Director is a member of the National Board of Directors of NASDDDS which has helped keep SC DDSN abreast of upcoming national changes and trends. It will be

important for SC DDSN to continue to monitor these changes to ensure that they remain compliant with the new requirements.

8) *SC DDSN should implement a 1915(k) Community First Choice program*

This recommendation encourages SC DDSN, in conjunction with SC DHHS, to take advantage of a 2012 final rule promulgated by CMS that implemented section 2401 of the Affordable Care Act, which added a new section, 1915(k), to the Social Security Act. This rule implemented a new State option for home and community-based attendant services and supports, known as Community First Choice (CFC). The CFC option has several benefits for states including a six percent higher federal match for program expenditures, the ability to invest savings in the implementation of the program and the reduction of waiting lists, the encouragement of the use of self-direction and promotion of attendant care services, the ability to permanently waive the annual recertification requirement for individuals based on certain criteria, the enhanced controls of utilization, and the authorization of expenditures for items like rent and utility costs to assist persons in an institution to transition to the community. In considering this recommendation, SC DDSN would need to weigh the benefits this waiver could provide against the additional financial liability for the State created through the additional funding requirements of the waiver. SC DDSN would also need to consider its current efforts in working with SC DHHS in implementing a 1915(i) waiver when determining the feasibility of also implementing this 1915(k) waiver.

9) *SC DDSN should continue to review the National Core Indicators with providers and consumers*

The National Core Indicator results are significant measurements of the experiences of program beneficiaries and can be a useful tool in helping to guide in promoting system improvements. SC DDSN has a history of successfully engaging stakeholders in meaningful discussions on a range of topics including quality related data and would benefit from continued discussion with all stakeholders. SC DDSN has engaged provider organization with summary information and discussion of the NCI data. Inclusion of additional stakeholders would allow for a greater sense of ownership across all levels of the system while promoting transparency in the decision making of the Department.

As evidenced in our recommendations and in the narrative on the current business practices of SC DDSN, PCG believes that the Department takes great pride in ensuring that appropriate and quality care is available to the most vulnerable individuals in South Carolina and has made great improvements in their own practices in an effort to improve the availability and quality of care provided through their network of providers, both public and private. PCG's recommendations are indicative of a system that could be further enhanced not through complete overhaul but rather through efforts to modernize the system, such as the automation of the annual cost report process or the consideration of a newer, more current service delivery system model that retains the core functions and benefits of the OHCDs. In some cases, SC DDSN has already begun efforts in the areas of piloting a national assessment tool and reviewing the National Core Indicators with



providers and consumers and PCG's recommendations are intended to encourage the Department to continue those efforts. Other recommendations are targeted at helping to keep SC DDSN in line with national trends and best practices.

II. Background and Introduction

Public Consulting Group, Inc. (PCG) was contracted by the South Carolina Department of Disabilities and Special Needs (The Department, or SC DDSN) to conduct a review of its current business practices including its Organized Health Care Delivery System, data and systems integrity, and related processes associated with Medicaid billing and Medicaid cost reporting and administrative cost allocation. SC DDSN has recently been the subject of audits and program reviews by the Legislative Audit Council (LAC), the South Carolina Department of Health and Human Services (SC DHHS), and the US Health and Human Services Office of the Inspector General (OIG) and that as a result of these audits/reviews the Department has undertaken an internal effort to review its policies and practices to ensure compliance and make program improvements.

Background on South Carolina Department of Disabilities and Special Needs

The South Carolina Department of Disabilities and Special Needs (SC DDSN) is the state agency that plans, develops, coordinates and funds services for South Carolinians with intellectual disability, autism, traumatic brain injury and spinal cord injury and conditions related to each of these four disabilities, as per South Carolina Code of Laws §44-20-250. SC DDSN serves approximately 30,000 consumers with lifelong disabilities through an Organized Health Care Delivery System with a network of its Regional Centers, 39 local Disabilities and Special Needs (DSN) Boards and 33 Qualified Providers (QPLs).

While SC DDSN provides services that address these specific disabilities, SC DDSN also works with other state agencies to coordinate, arrange for, and deliver services to eligible persons, such as education, public health, mental health, housing, and social services. SC DDSN's specialized services supplement and enhance, not replace, services provided by other state agencies. SC DDSN also advocates on behalf of all citizens with severe, lifelong disabilities and special needs to ensure that their needs are addressed by the appropriate state, federal and local agencies.

In a contractual relationship with the South Carolina Department of Health and Human Services (SC DHHS), SC DDSN provides Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) services as well as various waiver services. Programs operated by SC DDSN account for approximately \$560 million of SC DHHS's Medicaid spending annually, or roughly 9.4 percent of the state's total Medicaid budget⁴.

Eligibility for services furnished through SC DDSN is determined, as defined within SC Code of Laws, Title 44, Chapter 20, based on an individual's need for services identified through the defined assessment process and not by the individual's financial status or ability to pay. As such, services are furnished, when sufficient funding is available, to those individuals that have identified needs based on their diagnosis and not as an entitlement driven by financial status.

⁴ Letter from Anthony E. Keck to Beverly A.H. Buscemi, Ph.D., State Director of South Carolina Department of Disabilities and Special Needs, Dated February 26, 2013.

Individuals that are determined to be eligible based on their diagnosis have access to services within the five major areas / primary services offered through SC DDSN includes Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and the four waiver programs operated by SC DDSN under Title XIX section 1915(c) of the Social Security Act (the Act). These are waivers approved by CMS that cover long-term services and supports for individuals with intellectual or related disabilities, and includes home or community-based services. SC DHHS provides administrative oversight and monitoring of the waiver programs and contracts with DDSN to provide the following four 1915(c) waivers:

- Community Supports (CS) Waiver
- Head and Spinal Cord Injury (HASCI) Waiver
- Intellectual Disability and Related Disabilities (ID/RD) Waiver
- Pervasive Developmental Disorder (PDD) Waiver

In addition to the ICF/IID and waiver services, SC DDSN provides Early Intervention services to children who are eligible for Part C (BabyNet) services under the Individuals with Disabilities Education Act (IDEA) and for those children who are eligible or are in the process of pursuing eligibility for services through SC DDSN. First Steps is the State's lead agency for Part C (BabyNet) services under IDEA, and contracts with SC DDSN to provide services to children birth to three in accordance with Part C requirements.

In order to ensure sufficient availability and choice of service providers across the state for individuals, SC DDSN offers services through public, SC DDSN funded, DSN Boards and through qualified, private contract providers known as QPLs. SC DDSN, with the DSN Boards and the QPLs function under a model known as an organized health care delivery system (OHCDS).

The term "organized health care delivery system" comes from federal regulation, 42 C.F.R. ' 447.10(b), which defines OHCDS as a "public or private organization for delivering health services." An Organized Health Care Delivery System (OHCDS), such as SC DDSN, is commonly described as a clinically integrated care setting in which individuals typically receive health care from more than one health care provider⁵. In a 1993 State Medicaid Director Letter (SMDL), the Centers for Medicare & Medicaid Services (CMS) (then HCFA) offered guidance to states regarding alternative payment options that would allow intermediary organizations to pay providers and presented the OHCDS as an option. The South Carolina legislature customized this OHCDS option to benefit South Carolinians with intellectual disability, autism, traumatic brain injury and spinal cord injury and conditions related to each of these four disabilities, and formalized SC DDSN as an OHCDS in 1993.

⁵ See retrieved on 8-7-2013 from http://www.integration.samhsa.gov/operations-administration/organized_health_care_delivery_system.pdf

Scope

For this engagement, PCG provided the following services:

- Reviewed and analyzed prior audits conducted by various state and federal entities as well as recent requests for audits from state entities and SC DDSN's response to the prior audits and findings. The audits reviewed include:
 - South Carolina Legislative Audit Council, *Review of the Department of Disabilities and Special Needs by Legislative Audit Council (LAC), December 2008*;
 - South Carolina Department of Health and Human Services (SC DHHS), *Review of the MR/DD Waiver by the Division of Audits, February 2006*;
 - South Carolina Department of Health and Human Services (SC DHHS), *Limited scope review of the Medicaid Service Coordination (Targeted Case Management) by the Division of Audits, August 2007*;
 - South Carolina Department of Health and Human Services (SC DHHS), *Review of Greenville Board by the Division of Audits, June 2013*;
 - United States Department of Health and Human Services (US DHHS) Centers for Medicare and Medicaid Services (CMS), *Letter denying Medicaid program match for claimed OHCDs administrative expenses by Centers for Medicare and Medicaid Services (CMS), July 2010*;
 - United States Department of Health and Human Services (US DHHS), Office of the Inspector General (OIG), *Report on unallowable room-and-board costs under the intellectual and related disabilities waiver by the US Health and Human Services Office of the Inspector General (OIG), September 2012*;
- Reviewed and analyzed the SC DDSN processes associated with Medicaid cost reporting and reimbursement methods. Analyzed current models for best practices and to address concerns raised by the LAC (*ex. Finding #44*). Made recommendations for strengthening internal controls and overall improvements including comparing current models to other State's approaches;
- Reviewed and analyzed SC DDSN business processes, including the Organized Healthcare Delivery System and assess the strengths and weaknesses of a centralized model (i.e. Public Provider) for provider billing and oversight versus direct billing by providers for Medicaid services;
- Reviewed SC DDSN data and systems integrity to provide feedback as to controls and effectiveness with regard to data integrity (CDSS – Client Data; ANE – Abuse Neglect Exploitation; Provider reported statistical and financial data, etc.). This includes a review of the CMS approved QIO, QA contractor, Alliant, and their controls and integrity measures, as well as a review of SC DDSN oversight and assurances with regards to Quality of Direct Care Staffing, particularly in the residential setting(s);
- Provided independent analysis of SC DDSN overall business practices and systems and make recommendations to improve agency efficiency and effectiveness in meeting the needs of the specialized populations served; and

- Developed a final report detailing PCG's review of SC DDSN including analysis and recommendations for improvement.

It is important for the Department to receive an independent, unbiased review of their current operations to identify strengths of the current system as well as weaknesses that could be improved upon to ensure that SC DDSN is operating in the most efficient and effective manner. In our professional opinion, PCG has no conflicts of interest with this review that would disqualify us from providing un-biased observations and recommendations.

The following report presents PCG's review of SC DDSN on each of the components outlined above. The first section presents a summary of each recent audit and review of SC DDSN and its operations. The second section then assesses the current reimbursement practices of the Department and its OHCDs. The third section reviews the current oversight practices. In assessing the strengths and weaknesses of SC DDSN's operations, PCG presents recommendations to gain efficiencies and effectiveness in its current environment.

PCG conducted on-site visits at SC DDSN's offices in Columbia, South Carolina, from May through July 2013. In June, PCG staff also visited four providers contracted with the Department and one Department operated provider, specifically:

- Whitten Center (DSN Regional Center; DDSN operated)
- Laurens DSN Board (DSN Board)
- Babcock Center (DSN Board)
- Richland-Lexington DSN Board (DSN Board)
- Community Options (Qualified Provider Listing (QPL))

PCG independently selected these providers based upon their representation of SC DDSN expenditures, region, and number of recipients served.

Methodology

To obtain a thorough understanding of SC DDSN's business processes, PCG used the following methods of data gathering:

- Met with Department officials to discuss the quality and risk management; central office and district office role and operations; information systems and data transfers; as well as cost reporting and Medicaid billing;
- Met with four providers contracted with SC DDSN and one SC DDSN operated facility;
- Collected and analyzed available SC DDSN data, including past audits conducted on SC DDSN, cost reports and overhead allocation schedules, waiver application and renewal materials supplied to SC DHHS, as well as the final application submitted to CMS;
- Talked with Alliant staff to discuss the quality assurance and licensing practices; and



- Met with SC DHHS agency officials to discuss the status of the Targeted Case Management and waiver programs.

III. Analysis of Current SC DDSN Funding and Reimbursement Practices

The funding for services provided through SC DDSN is driven by appropriations from the South Carolina General Assembly and Medicaid revenues generated through the provision of services to Medicaid eligible individuals. On an annual basis SC DDSN is required to develop a budget request that is submitted to the State Budget Division with the General Assembly responsible for approving the final appropriations made to the Department. The SC DDSN appropriation includes funds for both administrative expenditures and direct service expenditures including the state matching funds for Medicaid covered services, funds for services not reimbursable by Medicaid, and funds for the operation of the four regional centers. The following table provides a three year comparison of the appropriations from the SC General Assembly for SC DDSN and SC DHHS.

Table III-1: SC DDSN and SC DHHS Appropriations (All Funds) for Three Year Period

	FY 2012 – 2013	FY 2011 – 2012	FY 2010 – 2011
SC DDSN	\$568,448,265 ⁶	\$574,821,518 ⁷	\$525,976,312 ⁸
SC DHHS	\$5,938,305,336 ⁹	\$5,796,543,317 ¹⁰	\$5,766,840,751 ¹¹

Source: SC General Assembly Ratified Appropriations Bills

SC DDSN must ensure that these funds are used in the most efficient and effective manner to ensure that the greatest number of South Carolinians can access the services they need. The following sections provide additional details on core functions of SC DDSN that ensure the funds are used appropriately and accounted for in a transparent fashion. The core functions performed by SC DDSN including Medicaid cost reporting, rate setting, and provider billing are vital to ensure that the necessary funding for services is available to reimburse the service providers and allow the consumers to receive the necessary services in the most appropriate and least restrictive setting.

A. Funding for Services

One of the core responsibilities of SC DDSN is to ensure that the greatest number and most in need South Carolinians with intellectual and related disabilities, autism, traumatic brain injuries, or spinal cord injuries have access to services. In meeting this responsibility SC DDSN must

⁶ SC Ratified Appropriations Bill for FY 2012 – 2013, Section 24 – Department of Disabilities and Special Needs, http://www.scstatehouse.gov/sess119_2011-2012/appropriations2012/tas24.htm

⁷ SC Ratified Appropriations Bill for FY 2011 – 2012, Section 24 – Department of Disabilities and Special Needs, http://www.scstatehouse.gov/sess119_2011-2012/appropriations2011/tas24.htm

⁸ SC Ratified Appropriations Bill for FY 2010 – 2011, Section 24 – Department of Disabilities and Special Needs, http://www.scstatehouse.gov/sess118_2009-2010/appropriations2010/tas24.htm

⁹ SC Ratified Appropriations Bill for FY 2012 – 2013, Section 21 – Department of Health and Human Services, http://www.scstatehouse.gov/sess119_2011-2012/appropriations2012/tas21.htm

¹⁰ SC Ratified Appropriations Bill for FY 2011 – 2012, Section 21 – Department of Health and Human Services, http://www.scstatehouse.gov/sess119_2011-2012/appropriations2011/tas21.htm

¹¹ SC Ratified Appropriations Bill for FY 2010 – 2011, Section 21 – Department of Health and Human Services, http://www.scstatehouse.gov/sess118_2009-2010/appropriations2010/tas21.htm

apportion the funds appropriated from the South Carolina General Assembly and Medicaid revenues generated through service provision to the clients and services most in need. SC DDSN is assisted by Financial Managers in ensuring that funds for the community based services get to consumers and ultimately to the service providers. The Financial Manager role is generally filled by the DSN Boards as part of their administrative functions but may also be filled by entities that have been grandfathered as DSN Boards or by entities selected through a Request for Proposal (RFP) process known as Self-Directed Support Corporation (SDSC). A DSN Board may provide the service itself or subcontract with a qualified provider for the provision of the services while the SDSC must contract with a qualified provider for the provision of services.

In the current SC DDSN system there are two types of providers for community based services; DSN Boards and QPL providers. The DSN Boards were established in SC State Statute as the safety net for the developmentally disabled and special needs populations, are required to provide all services to any eligible individuals. The QPL providers are contracted with SC DDSN through an open procurement process and have the ability, unlike the DSN Boards, to choose what services they want to provide and who they want to serve. In addition to the differences in statutory requirements and service provision requirements between DSN Boards and QPL providers, a key distinguishing characteristic between the two provider types is that SC DDSN must provide funding to the DSN Boards. The QPL providers by contrast are not entitled to funding from SC DDSN beyond that agreed to in their contract for the provision of services.

While established in statute, the DSN Boards do not receive funding directly from the General Assembly. As a result, SC DDSN is responsible for ensuring that the necessary funding to keep the DSN Boards in operation are appropriately allocated. In order to facilitate this allocation of funds to the DSN Boards, SC DDSN developed a methodology known as the funding bands. The funding bands are commonly cited as a capitation system in that they apportion a finite amount of funds across an established provider base. The identification of the funding bands as a capitation system however has led to a general misunderstanding of the purpose and use of the funding bands. The funding bands are a mechanism developed by SC DDSN to ensure that the finite amount of state general fund dollars are appropriated in a consistent manner across the state. The funding bands are not a reimbursement methodology for Medicaid services.

From a reimbursement perspective the DSN Boards and the QPL providers are paid at the same rates and through a similar process. The DSN Boards and the QPL providers both submit the necessary service documentation and logs to SC DDSN to be used in generating Medicaid claims. The Medicaid reimbursement subsequently flows from SC DHHS back through SC DDSN and out to the DSN Boards and QPL providers.

The following sections provide additional details on the funding and reimbursement practices.

Capitated Funding Band Approach

The capitated approach known as the funding bands provides funding for a continuum of services provided to a consumer based on that consumer's identified needs. This approach to funding services is more appropriately defined as a budgeting system in that it allows for SC DDSN to manage the number of consumers served and the services provided within the confines of a finite amount of available funding resources. The funding bands are determined based on the average costs of services as identified from annual cost reports completed by the providers. SC DDSN has the ability to recalculate the bands annually based on updated provider costs however any changes to the funding bands are contingent upon the availability of new funds from the General Assembly. The funding bands were most recently updated in 2013 to reflect increased funding from the General Assembly to account for increases in health insurance and retirement costs.

As part of the process through which a consumer becomes eligible for services through the SC DDSN system an assessment is completed to determine the level of needs of that individual. Once the consumer is active in the SC DDSN system they can be placed in one of nine funding bands based on their service needs as identified through the assessment. These nine funding bands, broken out between six residential and three non-residential bands, are each based on the average cost of services in each level. Consumers within each of the funding bands can receive a core set of services with the potential to receive enhanced supports associated with each band. The following section highlights the nine funding bands and some of the services and enhanced supports covered under each band¹².

Residential funding bands include:

- 1) Residential Higher Needs: consumers in ICFs/ID, Community Residential Care Facility – Higher Needs, and Community Training Home II – Higher Needs;
- 2) Residential Lower Needs: consumers in Community Residential Care Facility – Lower Needs and Community Training Home II – Lower Needs;
- 3) Supported Residential – Enhanced Community Training: consumers living in Enhanced Community Training Home I;
- 4) Supported Residential: consumers living in Community Training Home I;
- 5) Supported Residential – Supervised Living Program I: consumers in Supervised Living Program I; and
- 6) Supported Residential – Supervised Living II: consumers in Supervised Living Program II

All residential funding bands cover residential habilitation, day services, employment services and enhanced supports. Psychological services are enhanced supports that are considered part of the residential habilitation service. Enhanced supports within the residential funding bands but outside of the residential habilitation service definition include adult companion services, adult dental, adult vision, audiology, assistive technology, and prescription drugs.

Non-Residential funding bands include:

¹² Funding band details can be found in SC DDSN Departmental Directive 250-10-DD: Funding for Services. <http://ddsn.sc.gov/about/directives-standards/Pages/CurrentDDSNDirectives.aspx>

- 7) Family Supports – Home Supports – Intellectual Disabilities/Related Disabilities Home and Community Based Waiver
- 8) Family Supports – Home Supports – Community Supports Home and Community Based Waiver
- 9) Family Supports – Day Services or Employment Services only

Unlike the residential funding bands, the services available to consumers in the non-residential funding bands vary across the three bands.

While the funding bands are defined based on setting, the funds are flexibly driven by the specific needs of each consumer. An additional consideration within the funding band methodology is that two consumers within the same funding band may receive different services resulting in an excess of funding for one consumer and a shortage of funding for the other. It is expected that the Financial Managers use all available funds to meet the needs of consumers and that in this situation that the excess funding from the one consumer would be used to cover the shortage for the other consumer. The funding band approach also allows for requests for additional funding through an outlier request system when a consumer's circumstances and needs are substantially greater than the average.

Non-Capitated Fee for Service Approach

The non-capitated fee for service approach differs from the capitated approach in that reimbursement is made only for specific services as opposed to the group of services covered under the capitated funding band approach. The available services under this approach are defined by the disability or condition of the individual as outlined below.

- Individuals with Intellectual Disabilities – Related Disabilities or autism may receive service coordination and early intervention. Respite services are also available for individuals not enrolled in a Home and Community Based Waiver.
- Individuals with head and spinal cord injuries may receive service coordination, supported employment, individual rehabilitation supports, residential habilitation, day habilitation, prevocational services and respite.

While the two groups of providers receive their funding through different approaches, the rates between the two approaches are based on the same average cost data. The following two tables illustrate the rates for each of the funding bands and the associated services under the fee for service approach¹³.

¹³ Funding Band and QPL Rates are based on SC DDSN documentation issued November 28, 2012 to document adjusted rates for increases in health insurance and retirement funding.

Table III-2: SC DDSN Funding Bands effective January 1, 2013

Band	Band Definition	Funding Band Rate
Band A	Day Supports Only – Non Waiver Funded	\$ 8,592
Band B	At Home – MRDD Waiver	\$ 10,185
Band C	Supported Residential – SLP II	\$ 27,304
Band D	Supported Residential – SLP I	\$ 16,630
Band E	Supported Residential – CTH I	\$ 20,669
Band F	Supported Residential – Enhanced CTH I	\$ 34,368
Band G	Residential Low Needs	\$ 53,937
Band H	Residential High Needs	\$ 74,253
Band I	At Home – Community Supports Waiver	\$ 10,278

Source: SC DDSN service rate documentation, issued November 28, 2012

Table III-3: SC DDSN QPL Rates effective January 1, 2013

Service Description	Unit	QPL Rate
Residential High Needs – CRCF/CTH II	Daily	\$ 182.11
Day Rolled into Residential	Daily	\$ 205.65
Residential Low Needs – CRCF/CTH II	Daily	\$ 126.00
Day Rolled into Residential	Daily	\$ 149.54
Residential – HASCI CTH II	Daily	\$ 212.86
Supported Residential – SLP II	Daily	\$ 74.88
Supported Residential – SLP I	Monthly	\$ 1,381.23
Supported Residential – Enhanced CTH I	Monthly	\$ 2,319.24
Day Supports	Half Day	\$ 16.52
Supported Employment – Individual	Hour	\$ 50.37
Service Coordination – Annualized	Monthly	\$ 109.58
Service Coordination – 1/1/13 – 6/30/13	Monthly (2 nd half of FY13 only)	\$ 110.35
Early Intervention – Family Training	15 minutes	\$ 22.05
Early Intervention – Targeted Case Management	15 minutes	\$ 20.38
Respite	Hour	\$ 8.30 - \$ 15.00
Personal Care 1	15 minutes	\$ 2.93
Adult Companion	Hour	\$ 10.26

Source: SC DDSN service rate documentation, issued November 28, 2012

In their 2008 audit of SC DDSN, the LAC provided two recommendations specific to the funding bands. The first, item #37, recommended that SC DDSN develop a formal policy on the funding bands and make that policy available to the public. The second item, #38, recommended that SC DDSN develop a plan to update the band calculations annually to account for cost of living adjustments. In response to item #37, SC DDSN currently publishes Departmental Directive 250-

10-DD which outlines the funding bands and the Department's policy regarding the determination of the funding bands. This Directive also provides additional information regarding the outlier funding request process and the mechanisms in place to ensure consumer freedom of choice within the system. The recommendation calling for the development of a plan to update the band calculations on an annual basis presents a different challenge for SC DDSN. While the Department is able to review and monitor the provider costs and funding bands on an annual basis, updates to the rates are contingent upon the General Assembly increasing the funding to SC DDSN.

B. Provider Service Reporting and Billing

Within the construct of the Organized Health Care Delivery System SC DDSN serves as the central Medicaid billing entity for all Medicaid services provided through the DSN Boards. The QPL providers may also use SC DDSN as their Medicaid billing entity however they also have the ability to bill Medicaid directly. Currently, every QPL provider and DSN Board uses SC DDSN as the central billing entity for Medicaid services. In this capacity, SC DDSN collects all of the service data from the DSN Boards and the QPL providers and submits all appropriate claims to SC DHHS for Medicaid reimbursement.

For the DSN Board providers, funding is disbursed by SC DDSN twice per month regardless of the documentation of a Medicaid billable service. That is, the DSN Boards receive their funding from SC DDSN in advance of submitting the service documentation to SC DDSN to generate the Medicaid claims. The QPL providers can receive reimbursement from SC DDSN twice per month however unlike the DSN Boards they must submit the service documentation to SC DDSN prior to receiving payment. The DSN Boards and the QPL providers must both submit service documentation through the SC DDSN CDSS system in order for SC DDSN to generate claims for submission to SC DHHS.

Once the necessary service logs have been certified by the provider and submitted to SC DDSN through CDSS, the Department begins the process of generating claims for submission to SC DHHS. The service log data from CDSS is matched to Medicaid eligibility files and the resulting Medicaid service details are extracted to Medical Manager which allows for the creation and submission of the claims to SC DHHS. Services not reimbursable under Medicaid are funded through the SC DDSN appropriations from the General Assembly.

As previously noted, the DSN Boards receive funds from the Department twice per month based on the budgeted funds aligned with their consumers through the funding bands which may result in the DSN Board receiving funding for a service without having provided that service during that period. SC DDSN will only reimburse the QPL providers once they receive the necessary documentation, however the Department will pay the providers prior to receiving the Medicaid reimbursement from SC DHHS. In the event that a claim is rejected by SC DHHS, SC DDSN does not recoup funds from the provider but rather funds the payment with general revenue funds in the Department's appropriation.

There have been recent efforts outside of SC DDSN to move DSN Boards and QPL providers from the current billing process through SC DDSN to a direct billing process through SC DHHS similar to that of other Medicaid providers. There have been DSN Boards and QPL providers that have considered this option however all providers continue to bill through SC DDSN. For the DSN Boards, the direct billing option would eliminate the ability for these providers to receive advance payments as they currently receive under the capitated funding band approach. Under the direct billing approach the DSN Boards would need to generate their own claims for submission to SC DHHS, conduct their own follow up efforts on rejected claims, and return payments to SC DHHS for any claims that were improperly paid, all of which would be a significant change from their current process under which these functions are all provided by SC DDSN. The QPL providers would still be reimbursed only after providing the service however, like the DSN Boards, under a direct billing arrangement these providers would need to generate their own claims for submission to SC DHHS, conduct follow up on any rejected claims, and refund any amounts claimed inappropriately to SC DHHS. Based on our meetings with providers, the prospects of increased and timelier reimbursement through direct billing have not been viewed as enough of a benefit to move from the current billing process through SC DDSN.

Bundled Rate versus Fee-for-Service Billing

One item that has been part of an ongoing discussion in South Carolina but also nationally is that of bundled rate versus fee-for-service (FFS). Under a bundled rate methodology, providers receive a single payment that covers an array of services furnished within an established period of time, generally in the form of a per diem or monthly rate. The FFS methodology provides reimbursement for every individual unit of a discrete service provided. A bundled rate methodology provides an incentive for the provider to furnish services in an efficient manner and to provide only those services that are needed to meet the needs of the consumer. The bundled methodology however limits the amount of transparency on the volume of each individual service provided within the bundle. In contrast, under the FFS methodology, a provider is incentivized to furnish as many units of service as possible in order to maximize their reimbursement. While the FFS methodology allows the payor to more discretely track the exact number of each service provided it doesn't incentive providers to furnish services in the most efficient manner.

In recent years with the expansion of Medicaid managed care there has been a move towards a bundled, capitated methodology in which a the provider assumes the risk for providing services within the established rate for the set of services. This movement towards managed care and bundled payments has been driven by the desire of states to contain spending on healthcare services and in particular on unnecessary and excessive utilization more commonly found under a FFS methodology. In states like North Carolina and Virginia, for the non-managed care populations, reimbursement for Medicaid services covered under their respective waiver programs is based on FFS rates as opposed to bundled rates. While these two states have chosen to utilize a FFS methodology for their waiver services, SC DHHS and SC DDSN have the ability to maintain a bundled rate methodology for the waiver services as long as the rates meet the appropriate state and federal requirements.

C. Medicaid Cost Reporting

According to the Medicaid State Plan language covering the services provided through SC DDSN, the reimbursement for Medicaid services is cost based. This methodology utilizes an interim rate, established by SC DHHS and based on historical cost data from SC DDSN, to reimburse SC DDSN for claims submitted throughout the fiscal year. At the end of the fiscal year, SC DDSN as the Medicaid billing provider for all services provided through the DSN Boards and QPLs is responsible for submitting a cost report to SC DHHS. The SC DDSN cost report is used to conduct a cost settlement process in which the Medicaid allowable costs, as determined in the cost report, are compared to the interim payments made for services rendered during the fiscal year.

As part of our review of the current Medicaid Cost Reporting processes PCG interviewed key staff members of SC DDSN regarding business practices undertaken by the Department and to review cost reporting policies and procedures. Our analysis was based on a high level review and focused on the policies and procedures employed by SC DDSN in completing the cost reporting process. PCG was not tasked to audit actual cost reports or validate/attest to any of the information provided by the provider agencies or SC DDSN. Our work included taking an in depth look at the current cost reporting tool along with provider instructions and SC DDSN staff desk review procedures.

PCG reviewed the following documents in performance of this engagement:

- 250-05-DD - Medicaid Cost Principles
- 250-10-DD - Funding for Services
- 250-09-DD Calculation of Room and Board for Non-ICF Programs
- 275-04-DD - Audit Policy
- DSN Board Cost Report Forms and Instructions
- Cost Analysis Cost Report Desk Review Procedures
- Residential Fiscal Training - May 28, 2013
- SC DDSN Letter 2-26-13
- Clifton Gunderson Report
- LAC 2008 Audit Report SC DDSN
- SC DDSN Response to LAC 2008 Audit
- LAC 2013 Audit Current Questions
- Example of a Region's Cost Report Documents, Supporting Backup, and SC DDSN worksheets

The SC DDSN Medicaid cost reporting process begins with information reporting templates that include a series of cost reporting schedules to be completed by each Board contracted with SC DDSN to provide consumer services. The cost reporting templates include the following forms:

- Financial and Statistical Report for Nursing Homes

- Schedule A: Financial and Statistical Report for MR/RD HCB Waiver Program
- Schedule D: Financial and Statistical Report for Adult/Child Day Habilitation
- Schedule E: Financial and Statistical Report for Supported Employment
- Schedule R: Financial and Statistical Report for Residential Habilitation
- Schedule S: Financial and Statistical Report for Board Billed Enhanced Services
 - MR/RD Home and Community Based Waiver Program
- Schedule A/Schedule S: Financial and Statistical Report for Head and Spinal Cord Injury Waiver Program (HASCI)
- Financial Report for Service Coordination
 - Includes Attachments I – IV
- Financial Report for Early Intervention
 - Includes Attachments I
- Schedule A/Schedule B: Financial and Statistical Report for the Rehabilitation and Support Services Program – Phase II

The SC DDSN cost reporting process is an intensely manual process. Providers complete the schedules manually and submit them to the SC DDSN staff that transfer the data to Excel workbooks, perform a series of cost allocation adjustments to the data, and transfer the information to an Excel based template of a CMS-2552 cost reporting form which is submitted to the SC DHHS.

The CMS-2552 cost reporting form submitted by SC DDSN to SC DHHS is actually a hospital cost report form. SC DDSN was previously required to use this form as they formerly operated hospitals; however, as of 1994 this practice has ceased. According to SC DDSN staff there had been discussions to move away from the CMS-2552 cost reporting form but actions were delayed due to department budget cuts.

The SC DDSN staff performs extensive work on the providers' cost reports received to prepare the data to be transferred to the CMS-2552 cost reporting form. The SC DDSN staff use expansive Excel work books for each provider. The provider's reported costs along with service statistics are used to break down allowable costs for the various programs including determining waiver and enhanced services related costs. There are expense reclassification adjustments, such as salaries and grants, along with cost allocations for general and administrative expenses made in the final CMS-2552 preparation process. In addition to the cost reporting forms the providers must submit a documented reconciliation between the cost reports and their financial statements completed by a certified public accountant (CPA). In preparing the final CMS-2552 cost reporting form the SC DDSN staff complete a number of supporting spreadsheets that are ultimately linked to the summary spreadsheet.

The provider cost reporting information is used to form SC DDSN rate schedules and serves to establish a basis for interim rates that are retrospectively cost settled. Further, this information is



used to develop funding bands, which are a budgetary system for the DSN Boards as previously described.

SC DDSN staff also work closely with the 39 DSN Boards and review financial statements presented to the DSN Boards on a monthly basis. An objective of this review process is to identify trends in fiscal performance and question unusual financial outcomes as compared to the prior periods' financial reports.

There are instructions which accompany the various cost reporting forms; however, the guidance is general in nature and appears to lack the detail needed for someone less experienced in completing the SC DDSN cost reporting forms. For example, there is not a glossary section in the instructions that defines abbreviations or common terms. In addition, the instructions lack reference to SC state directives, such as 250-05-DD, 250-09-DD, and 275-04-DD and federal cost principles.

SC DDSN does have written procedures guide to instruct staff on how to perform a desk review on the provider cost reports. The guide provides an overview regarding what schedules should be completed by the providers for various programs. In addition, the guide primarily serves as a check list to document that particular tasks have been completed for the various cost report forms. The desk review procedures guide does not contain a detailed narrative regarding how to perform the tasks listed in the checklist. Further, the guide does not include procedures regarding quality assurance reviews or identifying risk areas pertaining to errors or misreporting. Additionally, the desk review process does not include a review of the Medicaid service units reported on the cost reports as compared to the actual Medicaid service units paid. SC DDSN instead relies on an electronic data collection system for the accumulation of census data for day and residential services. This electronic data system serves as the official census data for all statistical reporting and eliminates the need for SC DDSN to rely on the service units included in the cost reports.

When performing desk reviews there is no formal process to identify audit risks, however the SC DDSN staff, based on their experience with the Department and having an understanding of the DSN Boards from a historical perspective, look at trends and the fiscal health of the providers when summarizing the CMS-2552 reports. In performing the desk review procedures the SC DDSN staff communicates with the provider and preparer of the cost reports on an open basis. Beyond the efforts of SC DDSN in conducting cost report reviews, external auditors are required to reconcile the cost reports to the audited financial statements, a process that provides assurances to the accuracy of the data in the cost reports.

SC DDSN provides occasional training to providers on an as-needed basis. Usually the DSN Board will contact SC DDSN and request training for new fiscal staff. There is not a lot of turnover in finance directors and there is a network of providers who work with each other regarding questions in completing the SC DDSN cost reports. Most of the DSN Boards have Certified Public Accountants (CPA) prepare their cost reports with only a small number of DSN Boards choosing

to complete their own cost reports. The majority of the Boards, over 80%, have their financial statements audited and cost reports prepared by one of two CPA firms. The advantage of this is that these CPA firms are more likely to have specialized, knowledge in SC DDSN program services and completing Medicaid cost reports. However, this may pose some risk with only two CPA firms handling these functions, year after year, further adding merit to periodic independent audits of the final cost reports and supporting documentation.

SC DDSN Audit Policy, 275-04-DD, does require Boards' financial statement audits to be completed by a CPA. Also, the audit policy requires providers to engage in agreed-upon procedures with the CPA. As of June 30, 2013, entities receiving funding in an amount of \$250,000 or more are required to have a CPA audit for agreed upon procedures in regard to the provider's controls in place and procedures pertaining to Medicaid billings. The audit policy provides good detail in the narrative and audit expectations, including provider corrective plans of action. The SC DDSN desk review procedures regarding the review and use of the cost reporting forms is heavily dependent on this audit policy in providing assurance in regards to the accuracy and validity of the DSN Boards financial figures used to prepare the CMS-2552 cost reporting form.

Certified Public Expenditures (CPE) vs. Inter-Governmental Transfers (IGT)

The annual cost reporting process documented in the previous pages is a requirement of SC DDSN due to the cost based reimbursement methodology used by SC DHHS for these services, known as Certified Public Expenditures (CPEs). This methodology is driven by the ability of SC DDSN, as a public entity and provider of services, to certify the amount of public funds used in providing the services to Medicaid eligible consumers. In this situation, SC DDSN receives, as part of their annual appropriation from the SC General Assembly, the state funds that will be used to draw down the matching Federal funds for Medicaid covered services and consumers. SC DDSN then allocates these funds out through the funding bands and fee for service (FFS) payments to the DSN Boards and QPL providers.

At the end of the fiscal year SC DDSN must identify, through the Medicaid cost report submitted to SC DHHS, how much in state and local funding was used to provide the Medicaid covered services to Medicaid eligible consumers. This Medicaid cost is then compared to the Medicaid payments made by SC DHHS to SC DDSN to determine the annual cost settlement. SC DHHS then has the ability to use the public expenditures as certified by SC DDSN to request additional Federal matching funds if the Medicaid allowable costs were in excess of the Medicaid payments made by SC DHHS. Conversely, if the Medicaid allowable costs identified in the SC DDSN cost report were less than the Medicaid payments received by SC DDSN, SC DHHS would be required to recoup the overpayments from SC DDSN and return the Federal portion of that overpayment to CMS. This CPE process allows SC DDSN to maintain a greater level of oversight on how the funding is used and ensure that the greatest number of South Carolinians with disabilities and special needs receive appropriate care. The CPE methodology also allows for the possibility that additional Federal funds can be claimed if SC DDSN's costs for providing Medicaid services exceed the amount of reimbursement received for the same services throughout the year.

An alternative mechanism that is available to states for the funding of Medicaid services and that has been discussed recently by SC DHHS in regards to the SC DDSN system would be through an inter-governmental transfer (IGT) process. In an IGT process, SC DDSN would continue to receive the “state share” funds as part of their appropriation from the SC General Assembly. SC DDSN would then “transfer” these funds to SC DHHS who would then have control of the funds similar to the “state share” funds they receive in their appropriation for all other Medicaid services. A shift to an IGT process from the current CPE process could result in significant changes in the SC DDSN system. Under the IGT methodology SC DDSN no longer has the ability to manage the “state share” funds as they currently do under the CPE methodology as SC DHHS would be responsible for leveraging these funds to capture the Federal matching funds for the Medicaid services. Additionally, under an IGT approach, the funding bands and the advanced reimbursement to the DSN Boards may be dissolved as SC DHHS would not fund providers in advance of receiving the necessary service documentation and claims data to support that a service has been rendered. Lastly, under the IGT approach, the State’s ability to claim for the actual costs of services above the interim reimbursement for those services would be minimized as the “state share” funds would be transferred to SC DHHS and directly used for the Federal matching funds.

Regional Center Cost Reporting

PCG reviewed the cost reporting processes for the four SC DDSN regional centers including the individual regional center cost reporting workbooks in an effort to better understand approach used by SC DDSN to ensure that all costs are appropriately included and identified within the cost reports. As part of this review, PCG focused specifically on the SC DDSN Central Office expenses allocated to each facility in order to determine if the regional center cost reports included a representative amount of SC DDSN Central Office allocations for items such as administrative and employee benefit expenses.

In conducting this review, PCG reviewed the cost report workbooks for fiscal year 2011 for each of the four regional centers. PCG worked to track the flow of all expenses throughout the cost report, from the original trial balance on Worksheet A through the reclassifications and adjustments to the step-down of overhead expenses to patient service cost centers.

While PCG considered the results of the Clifton Gunderson study of the administrative costs associated with the four Medicaid waivers during this review, it is important to note that PCG’s review of the regional center cost reports was focused on the costs included for the purpose of calculating the per diem for each of the regional centers. To that end, PCG reviewed many of the same data points as the Clifton Gunderson review but with an emphasis on ensuring that the appropriate SC DDSN Central Office costs were being captured in the cost report as opposed to what costs were ultimately attributed to the four waivers.

Based on our review of the regional center cost reports, PCG has made the following observations regarding SC DDSN Central Office allocations in the regional center cost reports:

- SC DDSN does have a mechanism for capturing SC DDSN Central Office administrative costs and allocating these expenses to each region by cost center.
- Each of the four regions did receive a share of SC DDSN Central Office Administrative Costs allocation for the 2011 fiscal year.
- Each of the four regions received a share of administration and/or overhead allocations for the following categories of expenditures:
 - Central Office Administration Allocation
 - Central Office Capital Expense
 - Central Office Other Expense Allocation
 - Statewide Cost Allocation
 - District Expenditures Allocation
- The General Services Cost Centers section does include cost allocations for the Employee Health and Welfare cost center which was an area of concern in the prior fiscal year during the Clifton Gunderson review.
- Expenditures reported in the cost report workbooks do include reclassifications and adjustments with specific descriptions of the type of cost and/or why the transaction occurred.
- Expenditures reported in the cost report workbooks are broken down by a detailed listing of cost centers
- The Employee Health and Welfare cost center amounts for FY2011 presents some material differences as compared to the Clifton Gunderson reported amounts from the prior year.
- Further, the General Services Cost Centers section presents some significant variances regarding expenses allocated to particular cost centers when compared to the Clifton Gunderson reported amounts for the prior fiscal year 2010.
- The cost reporting workbook does contain inter-related worksheets that use the adjusted costs to step down these costs to particular units and then to calculate a per diem based on the adjusted allowable costs and facility patient bed days.

In order to determine if the appropriate and proportionate share of SC DDSN Central Office expenses were allocated to these four regions across the various cost centers further in-depth review of the SC DDSN's Central Office FY 2011 expenditure statements and internal cost allocation plan along with the regions FY2011 cost reporting workbooks would need to occur.

Process for administrative cost analysis

PCG reviewed the Clifton Gunderson Report to gain an understanding of the issue surrounding how SC DDSN operational expenditures incurred in administering four Medicaid Waiver programs were allocated as administrative costs and what measures were being taken to become compliant with CMS policy regarding the allocation of administrative costs on the Medicaid CMS 64 form. The study explains the methodology for allocating SC DDSN operational costs which incorporates the use of the SC DDSN provider cost reporting tool in recording these expenses to the Administrative and General cost centers on each regional Intermediate Care Facilities for

Mental Retarded services (ICF/MR) cost report for allocation to the program services provided by SC DDSN.

In reviewing the documents and spreadsheets used in the SC DDSN Medicaid cost reporting process we identified that there is a mechanism for capturing administrative costs and allocating these expenses to appropriate cost centers based on the provider's cost allocation plan.

Concern raised by the LAC (ex. Finding #44)

The SC General Assembly Legislative Audit Council (LAC) performed a review of SC DDSN fiscal practices and issued a report dated December 2008. As a result of this review the LAC addressed two recommendations that specifically pertained to the cost reporting process as follows:

- #43) The Department of Disabilities and Special Needs should arrange for independent audits of all of its most recent fiscal year Medicaid-filed cost reports.
 - SC DDSN addressed this item through an independent audit conducted by the Burkett CPA firm.
- #44) The Department of Disabilities and Special Needs should arrange for independent audits of all of its Medicaid-filed cost reports periodically as is appropriate based upon initial audit results.
 - Cost reports have not been filed due to a CMS administrative issue. SC DHHS has also already conducted two separate reviews of SC DDSN cost reports using external consultants.

The premise of these recommendations is that by not having a periodic, independent audit of SC DDSN's submitted Medicaid cost reports a significant gap in accountability for millions of dollars is incurred. It should be noted that subsequent to the LAC report, SC DHHS has hired multiple audit firms to conduct reviews of SC DDSN cost reports.

Although SC DDSN does have a specific audit policy in regards to provider's financial statements and the majority of providers engage certified public accountants (CPA) to complete the SC DDSN cost reporting tool there are not specific policies or procedures in place to periodically audit completed and filed Medicaid cost reports. This would entail a review of the annual regional reports that are completed and submitted to SC DHHS by the SC DDSN staff. Currently, there is not a formal SC DDSN internal quality assurance (QA) process in place to review completed Medicaid cost reports that are submitted to SC DHHS, however SC DDSN conduct an informal QA process on the cost reports. According to the SC DDSN staff, such formal QA reviews are not practical due to the small staff responsible for completing the Medicaid cost reports.

Although, the current SC DDSN staff who are responsible to complete the Medicaid cost reports have longevity and experience with the department; and, there is some level of quality assurance regarding the financial data received from the providers, due to SC DDSN's audit policy, there is

merit in employing a practice of having an independent audit as the Medicaid cost report is the basis used to claim Medicaid-allowable costs and establishing provider interim rates.

Analysis of SC DDSN Reimbursement Practices

The reimbursement practices of SC DDSN have come under scrutiny in recent years from state entities like SC DDHS and the Legislative Audit Council (LAC) as well as federal entities like the US Health and Human Services Office of the Inspector General (OIG). The issues raised by these entities have been focused primarily on the funding bands and the cost reporting practices of SC DDSN. The OIG audit, which was completed in 2012, focused on the inclusion of unallowable room and board costs in claims submitted for federal reimbursement under the SC DDSN operated waiver program. SC DDHS and the LAC have each raised concerns related to the calculation and application of the funding bands across providers.

The following sections details PCG's observations in regards to the reimbursement policies and practices of SC DDSN.

The funding bands are compliant with state Medicaid and Federal regulations

In our review of the funding bands PCG found that the methodology for calculating the rates was consistent with Federal regulations and state Medicaid rules. The rate calculation includes actual costs based on cost reports submitted by the DSN Boards to SC DDSN and are based on the average costs for the services within each band. As SC DDSN is the Medicaid provider responsible for the certification of the public expenditures under the CPE reimbursement methodology, it is reasonable for the Department to subcontract through the DSN Boards and the QPL providers for the provision of services under agreed upon reimbursement structures. Any expenses incurred by SC DDSN through these subcontracts and paid for using state or local funding sources would be eligible for inclusion in the determination of the Medicaid costs under the CPE methodology. It should be further noted that as a funding approach to apportion State General Fund dollars appropriated to SC DDSN out to the DSN Boards and not a methodology for Medicaid reimbursement, SC DDSN has the ability to set the funding bands in a manner that best meets the goals and needs to the Department, regardless of Medicaid regulations.

Misunderstanding of the funding band approach could be minimized with increased communications from SC DDSN

PCG did not interview any consumers or families as part of our analysis however our research and meetings with providers indicated that there still exists some misunderstandings of the funding band approach. The big misunderstanding around this approach is centered on the belief that the money follows the person regardless of the setting for which they are funded. For example, if a consumer moves from one of the residential settings to an at home setting, there exists a belief that the same level of funding would be available for the consumer in the at home setting as was available in the residential setting. This is however, not the case as the funding available for a consumer is based on their service needs, which factors in the setting in which they are being served. While SC DDSN has provided details on the funding for service through Departmental

Directive 250-10-DD to improve the general understanding of the funding process, additional educational efforts by the Department could help to reduce confusion on this process.

DSN Boards and QPL Providers Benefit from SC DDSN's role in Medicaid Billing

In the current system, SC DDSN serves as the Medicaid billing provider for all services provided by the DSN Boards and all QPL providers. In this role, SC DDSN has helped to minimize the administrative burdens and reduce the amount of overhead costs for their service providers as they do not have to hire additional staff to perform the claiming activities nor do they have to perform the burdensome activities associated with denied claims. The providers also have the benefit of receiving payment from SC DDSN in a consistent manner. That is, the DSN Boards receive their twice a month band payments and the QPL providers receive their payments once they have submitted the necessary service documentation to SC DDSN. Lastly, in the event of any audits, SC DDSN as the Medicaid billing provider assumes the responsibility for responding to any audits, findings or disallowances, further reducing the administrative burdens on the provider community.

The Medicaid Cost Reporting Process Requires Significant Manual Effort

The current process for the Medicaid cost reporting is a manual process with a number of intermediate steps needed to transfer the individual cost reports from the 39 DSN Boards to the one cost report for SC DDSN that is ultimately submitted to SC DHHS. The SC DDSN staff receive the cost reports from the DSN Boards as "hard copies" or paper based reports and then review and enter the data in to Excel templates that ultimately roll up in to a summary report. That summary report is then transferred in to an Excel based version of the CMS-2552 hospital cost reporting form. The manual nature of the process, while not cited by prior audits as an area for concern, is one that lends itself to increased possibilities of errors such as the inclusion of incorrect costs in the determination of rates or an over/understatement of costs on the SC DDSN cost report submitted to SC DHHS.

IV. Analysis of Current SC DDSN Program Oversight

SC DDSN oversight of programs is accomplished through a mosaic of efforts occurring at different organizational levels. South Carolina Code of Law Title 44 Chapter 20 at 44-20-240 and 44-20-250 establishes and describes the duties of SC DDSN.¹⁴ The language of 44-20-240 simply reads that the Department "...has authority over all of the state's services and programs for the treatment and training of persons with intellectual disability, related disabilities, head injuries, and spinal cord injuries". The duties enumerated include the coordination, negotiation, and contracting for services, as well as developing service standards for programs, and reviewing and evaluating these programs on a periodic basis.

SC DDSN exercises quality management leadership and accountability at three levels: *the program participant, the provider level, and the Department level*. In varying capacities, each level of accountability participates in interrelated quality management activities: licensing, contract compliance review, risk management, personal outcome measures, customer satisfaction, and evaluating other quality indicators. The Department level can gather information from any of these six activity areas to assess performance.

Program participants are impacted by incident management and reporting follow up, and by case reviews and personal interviews completed as part of licensing and quality assurance. In addition, customer satisfaction assessments are performed by all service providers throughout the state on a regular basis.

Providers are impacted by SC DDSN directives, service standards, and guidance affecting providers, which suggest and support quality assurance efforts. These numerous directives and standards are available online for all service areas rendered within the statewide service delivery system. Specifically this guidance includes:

- The SC DDSN Early Intervention Manual, Procedural Bulletin 12 [Monitoring and Quality Assurance](#)¹⁵, and
- The Administrative Indicators & Guidance Review Year July 2012 through June 2013.¹⁶

Within this regulatory context, providers have developed a range of management practices that impact quality. These include:

- The use of Quality Assurance (QA) coordinators;
- Encouraging peer review of houses in residential programs;

¹⁴ See SC Code of Laws at, retrieved on 7-24-2013 from <http://www.scstatehouse.gov/code/t44c020.php>

¹⁵ See retrieved on 7-25-2013 from <http://www.ddsn.sc.gov/providers/early-intervention/Pages/SCDDSNEarlyInterventionManual.aspx>

¹⁶ See retrieved on 7-25-2013 from <http://www.ddsn.sc.gov/providers/qualitymgmt/Documents/2012-2013%20Indicators%20and%20Guidance%20REVISED%20FINAL%20AUG%202012.pdf>

- Requiring local residential program managers to submit monthly checklists;
- Assigning staff to monitor and report on quality, critical incident, and risk management data;
- Encouraging weekly or monthly unannounced visits by lead staff and or managers,¹⁷ and
- Ensuring that staff receive needed training, such as 16 hours of medication administration.

At the Department level, SC DDSN has a Division of Quality Management, which performs four main activities:

- Critical Incident Reporting;
- Licensing and Surveys;
- Quality Assurance reviews of providers, and
- Risk Management

The Division also holds a Quality Management workgroup to review and guide the Department's quality management activity areas. For example, this workgroup reviews and uses previously met departmental quality assurance goals as benchmarks to measure progress against.

The SC DDSN licensing and quality assurance contracting is the most significant means of exercising oversight. However, SC DDSN also has a Division of Quality Improvement, which provides technical assistance and training to providers as well as hosting quality initiatives such as the "Reinventing Quality" Project.

SC DDSN has also periodically had reviews of its programs by third parties including a 2008 report conducted by the National Association of State Directors of Developmental Disabilities Services (NASDDDS), and the 2010 report conducted by Kerr.

A review of the quality assurance work shows that SC DDSN undertakes a large systematic quality assurance effort impacting persons in its programs and its provider staffs. SC DDSN derives its comprehensive approach to quality from relevant local ordinances, state statutes and regulations, federal statutes and regulations, applicable case law and court orders, funding source standards/requirements, and professional practice board standards. In addition, SC DDSN also looks to consumer goals, consumer satisfaction surveys, national accreditation boards (i.e. The Council, CARF, Malcolm Baldrige Award criteria), "best practices" that are emerging from educational and research organizations to establish its performance benchmarks. There is nothing about the regulations and organization of quality management that would prevent good care from being provided.

¹⁷ SC DDSN in its Residential Habilitation Standards requires "upper-level management" to make quarterly unannounced visits to the residential setting See Standard RH 1.3. retrieved on 7-25-2013 from <http://ddsn.sc.gov/about/directives-standards/Pages/CurrentDDSNStandards.aspx>

A. Existing Data Resources

Critical Incident Reporting

PCG discussed critical incident reporting with SC DDSN and provider staff, heard descriptions of how the reporting software operated, looked at report formats and the data reported.

There are nearly 30 critical incidents that are required to be reported along with an injunction that anything else that seems important should be also reported. Persons who have access to the SC DDSN Portal can use its web-based Incident Management System (IMS) to submit abuse, neglect and exploitation (ANE), Critical Incidents, and Death reports. SC DDSN has a full-time Incident Management Coordinator who reviews all incidents and supporting documentation submitted.

An examination of the types of critical incidents reported shows that in 2013 the four most reported types were major medical, aggression/assault, falls, and injuries. The reporting statistics show substantive changes over the 2008-2013 period in the numbers of reported types, e.g. reported accidents went from 188 in 2008 to 41 in 2013, and law enforcement went from 203 to 75. It is likely that policy changes influence how particular types are reported, but do not appear to affect the total number of incidents reported.

The table shows the number and rate of critical incidents reported for persons in residential and day services. The reported rate of critical incidents is approximately flat over the 2008-2013 period. The number of persons served and the number of critical incidents declined while the rate of reporting per person was effectively flat.

Table IV-1: Number of Persons in Residential and Day Services, Number and rate of Critical Incident Reporting, 2008-2013.

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
# Served-Unduplicated # served in Community Residential or Day Services:	8,251	8,186	8,103	7,907	7,881	7,880
Total # Cases Reported:	1,303	1,252	1,221	1,319	1,324	1,228
Rate Per 100 -CI Cases Reported Statewide	15.8	15.3	15.1	16.7	16.8	15.6

Source: SC DDSN CDSS system

Abuse Neglect Exploitation (ANE) Reporting

PCG discussed abuse, neglect, and exploitation reporting with SC DDSN and provider staff, heard descriptions of how the reporting software operated, looked at report formats, and looked at the data reported.

Reports of alleged abuse, neglect or exploitation are referred to state investigative agencies. The most prominent of which is the State Law Enforcement Division's (SLED) Vulnerable Adult Investigations Unit. Only SLED, other law enforcement, or state legal staff can make a determination of "founded" or "unfounded" on an abuse, neglect or exploitation report. This designation is not determinable by SC DDSN.

PCG examined report formats used within SC DDSN for the abuse, neglect and exploitation reporting. These formats included:

- ANE Allegation Detail Log;
- ANE Allegation Summary;
- ANE Reference and Consumer Listings;
- ANE Reinstatement Request Listing;
- ANE Reported Abuse Types;
- Audit Report for SC DDSN Review;
- Late Reporting Lists;
- Listing of Persons Involved in the Incident;
- Monthly and annual Case summaries, and
- Reports by Provider and Center of Final Disposition

The range and depth of reports are reflective of a mature system that has over time produced the numerous sub reports that system users request. The ANE reporting system appears capable of doing the tracking and counting it is intended to do.

The table below shows the number of allegations and substantiated allegations over the 2008-2013 period. The number of persons served went up, while the number of reported allegations dropped as did the number of substantiated allegations.

Table IV-2: Number of Persons in Residential Placement and the Number of Abuse, Neglect or Exploitation Allegations and the Number of Substantiated Allegations 2008-2013.

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
# Served in Residential Placement (excluding Regional Centers):	4,099	4,288	4,226	4,241	4,248	4,289
# Allegations Reported	526	510	426	420	413	452
# Allegations Reported (Substantiated):	50	17	18	10	8	0

Source: SC DDSN CDSS system

The table below considers persons in the SC DDSN Regional Centers. The table shows the number of allegations was basically flat over the five-year period from 2008 to 2012 despite a substantive dip in 2011. There are few substantiated allegations and the numbers did not vary much by year.

Table IV-3: Number of Persons in Regional Centers and the Number of Abuse, Neglect or Exploitation Allegations and the Number of Substantiated Allegations 2008-2012

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Consumer Residing in Regional Centers	1,099	873	838	812	816
# Allegations Reported	142	140	107	75	136
# Allegations Reported (Substantiated):	1	5	4	1	0

Source: SC DDSN CDSS system

There are consequences to an allegation. The 2013 DHHS audit of the Greenville Board shows reassurance that SC DDSN and the Greenville were exercising proper oversight because employees against whom allegations were made were immediately put on leave without pay and terminated if warranted.

The data systems used by SC DDSN appear capable of meeting the federal 1915(c) waiver assurance reporting requirements. These assurances require states to have quality performance measures and these measures entail mandatory reporting of abuse, neglect and exploitation data as well as their remediation.

Other Provider Reporting

PCG staff visited the Babcock Center and were provided the agenda and attachments of its April 24, 2013 Risk Management meeting. The meeting is a review of all recent significant events. These events span:

- Admissions/Discharges/Vacancies;
- Agency financial position;
- Allegations of abuse, neglect and exploitation;
- Clinical service report (four types);
- Employee drug testing;
- Employee injuries;
- Falls;
- Licensing and DHEC reviews;
- Medication error reports;
- Numbers of program participants;
- Psychotropic medications;

- Restraints;
- Staff Development and Training;
- Staff Turnover;
- Vehicle safety, and
- Worker's compensation claims.

A review of the material shows that considerable information was presented at the meeting. The minutes of the April 24, 2013 meeting show the Center's financial situation was first discussed in light of the negative impact of the Affordable Care Act (ACA) on the Center.¹⁸ The meeting next discussed data by topic. The data tables typically contained multi-year or multi-month data permitting readers to ask questions about trends and compare time periods. One report listed all medication-related errors and provided brief comment on each one.¹⁹ Summaries of types of medication errors by month were presented in a table and the table had a section called "Red Flag" events covering serious medication errors.

Similarly, all accidents and injuries were listed and each was described. Tables were presented showing monthly summaries by type of accident and injury. Similar descriptions and tables were presented for worker's compensation claims. The minutes of the April 24, 2013 meeting show that during the discussion of employee injuries, a suggestion was made regarding Hoyer Lift training. Other tables and graphs were presented covering the topics mentioned above.

The Center's staff appear to have ample data and discuss the data and trends. The documents examined were from the largest Center in the state and may not be representative of the scope and depth of data available at all providers. However, PCG's discussions with other providers indicate that similar data are available for them as well. At the provider level, there appears to be sufficient data to monitor the health of program users and the quality of care provided in programs.

B. Licensing and Quality Control

SC DDSN has two main contracts: one for licensing and one for quality assurance of providers.

Licensing Contract

A significant business practice is the licensing and surveying of programs. In the context of SC DDSN programs, the Department of Health and Environmental Control (DHEC) conducts the licensing and inspection of private residential treatment facilities (PRTFs), Community

¹⁸ The negative financial impact of the Affordable Care Act occurs because of the employer mandate to provide insurance. Babcock Center discussion estimated this impact to be \$250,000 in health insurance costs and additional unspecified cost in workers compensation payments.

¹⁹ Medication error reporting covers a broad range of medication-related events including finding medication on the floor, losing and then finding a medication packet, running out of medications, and not providing medications. None of the 13 medication errors described in the April 24, 2013 material actually involved a person being given the wrong medication or the wrong amount of medication.

Residential Care Facilities (CRCFs) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

The licensing and inspection of Community Training Homes, Supervised Living Programs, respite, and facility day services are contracted out by SC DDSN through a competitive procurement process.²⁰ When the Request for Proposals (RFP) was issued, SC DDSN had residential services offered within:

- 648 Community Training Homes – Level II;
- 147 Community Training Homes – Level I, and
- 226 Supervised Living – Level II programs.

Under the contract, the Licensing Contractor is responsible for:

- Initial, and Annual or Bi-annual Licensing Reviews for Residential services, Respite, and all Facility-based Day Supports programs;
- Special circumstances reviews at SC DDSN request, and
- Reviews Providers' Plans of Correction and does follow-up reviews as necessary

The scope of reviews includes basic health, safety, and welfare standards. The Contractor has the authority to enforce any and all of the guidelines within their purview. SC DDSN requires the Contractor to provide 24-hour notice before conducting a review. Interviews with providers indicated that agency management staff are present when reviews occur.

After reviews have been completed, if necessary, the provider has 15 days to prepare a “plan of correction” stating what remediation will be completed in regard to each low-scoring indicator. The Licensing Contractor does follow up reviews to see if plan of correction items are in fact completed and the initial concerns are corrected.

SC DDSN has established “thresholds” in both its licensing and quality assurance programs. When certain levels of specified deficiencies are reached, “consultation” is provided. In licensing there are eight thresholds, or triggers, that would result in a consultation. For example, one is being cited for a total number of Conditions and Standard level deficiencies that is 15% higher than the statewide average for three consecutive years.

PCG staff were given a demonstration of the licensing Contractor’s portal, called MedGuard. The Contractor uses a similar software management in other states and customizes the product for each state. The system shows, by provider, the scoring of the residential setting on each SC DDSN indicator, and provides summaries by type of indicator. The set of report formats also document

²⁰ The current holder of this contract is Alliant Health Solutions (the Contractor).

the plan of correction and track the completion of the plan of correction. Work statistics of the Contractor in regard to that provider are also shown.

SC DDSN, through its reliance on an outside contractor, does appear to have a reasonable methodology for ensuring its most difficult licensing surveys are taken care of. The scope of work required in its most recent licensing RFP appears to have been implemented. For example, the 2008 LAC audit studied 26 licensing reviews and found only two of them had follow up reviews and concluded that SC DDSN should institute more rigorous follow up of issues raised during quality assurance reviews of providers. The current licensing contract requires the Contractor to perform follow up reviews and the Contractor reports doing all of them.

SC DDSN has published summary reports by provider type and provider score based on the work done under the licensing contract.

Quality Assurance Contract

In July 2012, SC DDSN signed a five-year contract to provide quality assurance activities.²¹ The RFP created a Compliance Contractor to conduct quality assurance reviews of the Boards and other providers. The language in the RFP describes the scope of work of the compliance vendor.

“The Agency conducts or contracts 12-18 month assessments service providers by making on-site visits in its Contract Compliance Review (CCR) process. During this process, records are reviewed, consumers, and staff, and observations are made to make sure that services are being implemented as planned and based on the consumer’s need, that the consumer/family still wants and needs them, and that they comply with contract and/or funding requirements and best practices. In addition, provider’s administrative capabilities are reviewed on a 12 to 18 month cycle to ensure compliance with Agency standards, contracts, policies, and procedures. The Agency will impose sanctions including financial recoupments on providers which fail to comply with certain performance requirements.”

SC DDSN supplied PCG staff with documents describing the process. Providers are notified about two weeks prior to the visit. A cover letter is sent by the Compliance Contractor outlining the procedure and listing the documents that will be reviewed. Providers are asked to have appropriate staff and records available. The Contractor conducts the review, has an exit interview and follows-up with an official notification of the results. If necessary, providers have a 30-day period to respond with a plan of correction.

The review is complex. It covers the administrative capability of the provider including:

- Hiring of qualified employees;

²¹ The current contract is with Alliant (the Contractor).

- Reporting of abuse, neglect and other incidents;
- Handling consumer records and funds adequately;
- Making routine financial reports available to its Board or other authorities, and
- Complying with SC DDSN policies and procedures.

The review also establishes requirements for conducting an approximate 5% sample of persons and reviewing their case. If a review of the individual's case involves clinical decisions, then the Compliance Contractor is responsible for staffing the review team accordingly.

The review covers:

- The assessment data and process used to develop case plans;
- The degree to which the consumer's needs and preferences were listened to;
- Assurances that consumers actually received the services in their plan;
- That Federal 1915(c) regulations and Medicaid State Plan language were complied with;
- Assurances that any instances of abuse or neglect or other issues were dealt with, and
- Assurances that the plan protects the health and safety of the person.

In PCG's opinion this is a reasonable review procedure since it tracks the assessment data and how that fits with the consumer's needs and preferences. The plan developed for the person should reflect both the assessment information and the consumer's intent. The process used by SC DDSN checks to see if this occurred and goes on to check that the right services were provided the client.

If deficiencies are raised during the review, then a plan of correction is required within 30 days. All correspondence around the report of findings and plan of correction are done within the MedGuard system used by the contractor. The system tracks each deficiency cited in the Report of Findings and requires the provider to identify actions that will be taken to correct the deficiency, say when the deficiency will be corrected and who will be responsible for ensuring it has been corrected.

SC DDSN has published documents summarizing how much work has been done under the quality assurance contract.

Quality Assurance Contractor conducts 400 plus interviews using National Core Indicator questions

As part of its reviews, the Compliance Contractor conducts interviews with at least 400 consumers and administers the questions used in the National Core Indicators program.²² This permits the comparison of the state's answers with those of approximately thirty-eight other states. While state staff review the core indicator results, no report or broader discussion of the results with providers

²² See, retrieved on 7-23-2013 from <http://www.nationalcoreindicators.org/>

or contractors appears to take place. It is not clear how the indicator results are used to positively impact quality changes.

C. Direct Care Staffing

The quality of direct care staffing is multi-dimensional consisting of the:

- Design of duties and requirements of staff for positions, e.g. years of experience or education;
- Amount and kind of background checks on potential employees;
- Amount and depth of initial training required;
- Yearly educational requirements to maintain the position;
- Amount and kind of oversight of the employee's activities, and
- Level of payment for the position and the rate of turnover in the position.

A significant method of encouraging the component of quality in direct staffing is the setting of standards and their enforcement.

SC DDSN issues standards describing qualifications for potential employees within its programs and the nature and kind of criminal background checks made in relation to their prospective employment. For example the residential habilitation standards specify the age, experience and educational requirements for the person responsible for monitoring the residential care plan, and for the Support Provider that works directly with the person in the residential setting.²³ Yearly educational requirements are also specified by SC DDSN in its Directive 567-01-DD.²⁴

Criminal records checks for Support Providers are specified in SC DDSN Directive 406-04-DD.²⁵ Three of the Legislative Audit Council's 2008 review recommendations concerned criminal record checks. Two of them regarding Federal Bureau of Investigation checks for all direct care givers regardless of length of residency were contingent upon legislative action. Work on the practicality of the third resulting in a pricing of \$92,000 to implement and awareness that all results would come back through DHEC to process and have a workload impact on DHEC.

The enforcement of standards and directives occurs at the provider level through the SC DDSN Administrative Indicators & Guidance.²⁶ The list of indicators, their descriptions, and the

²³ See SC DDSN Residential Habilitation Standards, retrieved on 7-26-2013 from <http://ddsn.sc.gov/about/directives-standards/Pages/CurrentDDSNStandards.aspx>

²⁴ See DDSN Directive 567-01-DD: Employee Orientation, Pre-Service and Annual Training Requirements retrieved on 7-26-2013 from <http://www.ddsn.sc.gov/about/directives-standards/Pages/CurrentDDSNDirectives.aspx>

²⁵ See retrieved on 7-26-2013 from <http://www.ddsn.sc.gov/about/directives-standards/Pages/CurrentDDSNDirectives.aspx>

²⁶ See Administrative Indicators & Guidance Review Year July 2012 through June 2013, retrieved on 7-26-2013 from <http://www.ddsn.sc.gov/providers/qualitymgmt/Documents/2012-2013%20Indicators%20and%20Guidance%20REVISED%20FINAL%20AUG%202012.pdf>

assessment tool runs 79 pages. In 2012-2013, there were approximately 230 indicators subdivided into categories covering all aspects of program operations. Additionally there were another 93 indicators covering early intervention programs. With the exception of payment, the indicators cover quality issues usually associated with direct care staffing.

Ten of the 26 indicators in the A1 Administrative category refer to ensuring that staff hired had the right qualifications and that staff received the required number of hours of annual training. Samples of quality assurance deficiencies provided to PCG shows that quality assurance reviewers do observe and enforce these standards by sampling provider records. For example, to review if residential staff received their required 10 hours of training, a sample of ten percent or five residential staff hired during the review period is used.

PCG was provided samples of 114 deficiency descriptions. Two of the 114 involved a finding of a staff person that did not have their annual 10 hours of required training. These deficiencies may have been resolved differently. The deficiency information contains a statement of what the desired outcome is. The first agency wrote the stated improvement outcome of the deficiency was “Staff will receive training as required”. The second agency wrote the stated outcome of their deficiency was “... all staff present and future will have the required training and ongoing trainings set forth by SC DDSN directives.” These sound like different resolutions.

A deficiency can be resolved by solving the specific instance, e.g. the person is told to complete their 10 hours of training. A deficiency can also be resolved by seeking a general solution. For example, if a reviewer can find a direct care worker who did not complete the annual required training, then the provider clearly has no system that detects such events and needs to develop a system to monitor when their employees meet required training hours. Reviewers sample records and if a reviewer finds one person that did not meet training requirements, then it is likely that there are others in the workforce that were not sampled. Clearly, it is desirable to identify all instances of problems rather than claim the deficiency was resolved because one person fixed their training hours.

The larger issue is what is accomplished with the findings and what improvements in personnel hiring and training have resulted. What appears to be missing is a standardized method of identifying which person’s qualifications were consistent with position requirements and which persons are current in training requirements and which are not. For example, annual training requirements and continuing education credits in some state programs are processed through a single office that keeps track of who met their annual requirements.

D. Ranking of South Carolina's Program compared to Other States

United Cerebral Palsy (UCP) publishes an annual “scorecard” called the “Case for Inclusion” ranking the states on how well their state Medicaid programs serve persons with intellectual and developmental disabilities (ID/DD). In the 2014 report, South Carolina placed a respectable sixth highest in the nation having steadily improved its score over the last years from its rank of 16 in 2011.

The Inclusion scorecard ranks states on five main indicators and also provides an overall rank with the highest ranking state getting 1 on the indicator. On the 2014 report for the indicators:

- Promoting Independence. South Carolina ranked 33;
- Tracking Quality and Safety. South Carolina ranked 16;
- Keeping Families Together. South Carolina ranked 3;
- Promoting Productivity. South Carolina ranked 22;
- Reaching Those in Need. South Carolina ranked 13;
- Overall. South Carolina ranked 6.

As judged by the indicator scores, South Carolina ranks well overall compared to other states since it is in the first quartile of states. Consistent with other scorecard efforts such as Commonwealth's Health Scorecard and AARPs long-term services and supports scorecard, states vary on their indicator scores which is useful because low ranks point out where a state can do better. South Carolina does best, ranking 3th, on Keeping Families Together and worst, ranking 33, on Promoting Independence.

The Keeping Families Together indicator has two outcome measures: family support per 100,000 persons in the population and % in a family home. Compared to other states, South Carolina ranks high on these two indicator measures.

The overall ranking in the UCP scoring system is based on 100 possible points. Fifty of these points are associated with the Promoting Independence indicator. It is a complex indicator containing eight separate parts. An examination of the interplay and reasoning behind these parts is best left to state staff to review and understand how performance on this complex indicator could be improved.

Summary Comment on the Analysis of Current SC DDSN Program Oversight

Program oversight activities are intended to promote good, quality care and PCG's review has found that the Department has placed a significant emphasis on their program oversight efforts. A review of the activities undertaken by SC DDSN and its providers shows considerable effort has been made to set up data systems to collect quality related facts and that the facts are discussed by SC DDSN and provider staff. The role of the outside contractor has been expanded and is especially important as it provides objective information and third-party verification of provider practices.

V. Recommendations for SC DDSN

Based on our review and analysis of the current reimbursement and program oversight practices of SC DDSN, PCG has developed recommendations for the Department to consider in improving their current reimbursement and program oversight practices.

Recommendations for SC DDSN Funding and Reimbursement Practices

PCG's analysis found that the Department's reimbursement practices are compliant with Federal regulations for Medicaid reimbursement. The recommendations below are therefore focused on increasing efficiency within the current practices and more importantly on improving current practices in a manner that is more clearly understood by consumers, providers, and other entities outside the SC DDSN system.

SC DDSN should consider a move from the OHCDS model to a more current model

While PCG did not uncover any major concerns with the OHCDS model under which SC DDSN currently operates, the Department has been the target of recent criticism of the OHCDS model. In conducting a scan of the health care industry there are few systems operating under a similar OHCDS model. With a trend away from the historical OHCDS model towards new, integrated health care models encompassing multiple disciplines like physical and behavioral health care as evidenced by the growth in medical or health homes and other like models, PCG believes SC DDSN could benefit from a more in depth review of the existing OHCDS model and some of the more current models available to the Department. In addition to the considerations for the integrated care models like the medical or health homes, SC DDSN could consider models that include increased integrated employment opportunities or housing initiatives with state and/or federal housing authorities. In recommending that SC DDSN consider a shift from the OHCDS model to a more current model, PCG is not recommending that SC DDSN change its role in many of the vital functions it currently fills today including, but not limited to, setting program policy and establishing funding mechanisms for community based providers.

SC DDSN should continue its role in setting service rates for Medicaid and non-Medicaid services

In the event that SC DDSN transitions from the OHCDS to another model, PCG recommends that SC DDSN continue its role in developing service rates. PCG believes that SC DDSN possess a unique understanding of the services provided, the populations served, and the provider network that can be used to ensure that service rates are set in a manner that is appropriately aligned with the needs of the consumers and the system. Given the significant institutional knowledge at SC DDSN PCG recommends that SC DDSN retain responsibility for rate setting efforts for both Medicaid and non-Medicaid services. In this capacity, it will be imperative that SC DDSN work closely with SC DHHS to ensure that the rates established for Medicaid reimbursable services are done so in accordance with all federal and state rules and regulations.

SC DDSN should allow Medicaid payments to flow directly from SC DHHS to the QPL providers

One of the areas within the SC DDSN reimbursement structure that created the greatest confusion among providers and with SC DHHS was the process by which Medicaid reimbursement would flow from SC DHHS through SC DDSN and out to the providers. Adding to the confusion is the misunderstanding that the funding bands represent the Medicaid reimbursement for the services provided by the DSN Boards.

Given the relationship between SC DDSN and the DSN Boards it does not make sense to fundamentally change the processes currently in place for the funding of the DSN Boards and for the Medicaid claiming and reimbursement for the Boards. PCG recommends however that SC DDSN consider a change to the relationship with the QPL providers in regards to the Medicaid reimbursement process. This change would not impact SC DDSN's role as a clearinghouse for service logs that support claims for all Medicaid services provided by the QPL providers but would instead see SC DDSN removed from the Medicaid payment process with the payments flowing directly from SC DHHS to the QPL providers. PCG believes that SC DDSN's role in collecting all of the service documentation data and generating claims on behalf of the providers is an essential function and one that serves to ensure the integrity of the Medicaid claims.

SC DDSN should continue to pilot the use of a national needs assessment tool and consider a future alignment of the Funding Bands with the national needs assessment tool

SC DDSN has already begun a limited pilot program to utilize the American Association on Intellectual and Developmental Disabilities (AAIDD) Supports Intensity Scale (SIS) as part of its needs assessment process. PCG believes the use of this tool is an important step for SC DDSN and encourages the Department to continue its plan to expand its use statewide. While this tool is not currently linked to funding resources, PCG recommends that SC DDSN consider aligning funding resources with the SIS in the future. PCG believes that SC DDSN, by aligning the funding bands with the SIS tool, could more accurately align funding with the individual needs of the consumers. PCG recommends that SC DDSN continue to expand its use of the SIS as an assessment tool statewide before considering the recommendation to align funding resources with this tool.

The SIS is a tool that is designed to “measure the individual’s support needs in personal, work-related, and social activities in order to identify and describe the types and intensity of the supports an individual requires.”²⁷ Through the use of the SIS or similar tools, SC DDSN could more discretely identify the needs of the consumers and more closely align funding with those specific needs. Given that this pilot is in its early stages, there are no definitive results at this point, however PCG supports SC DDSN’s continued efforts through this pilot.

We noted during our reviews that there is the perception in the community that the use of the SIS in aligning funds with individual needs will result in consumers losing funding and access to services. While the possibility of a redistribution of funds exists through the use of SIS in determining the appropriate needs and funding, it will be done in order to more accurately align

²⁷ http://aaidd.org/publications/supports-intensity-scale#.UhPp47DD_Dc

funding with individual consumer needs so that those with the greatest needs receive appropriate levels of funding and that consumers requiring lower supports receive funding that is appropriate to their needs.

Lastly, it was also noted that the current process for determining eligibility and funding for services could be influenced by the ability of the service coordinators to present the case for their individual consumers. Through the use of a national tool such as SIS for determining needs and the associated funding levels, the ability of service coordinators to influence the determinations is minimized resulting in a more fair process for the consumers.

SC DDSN should enhance the documentation for Cost Reporting Policies and Procedures

Interviews with SC DDSN staff illustrated the significant wealth of knowledge and experience of the staff in regards to the Department's practices for Medicaid cost reporting. These staff possess an intricate understanding of each of the providers from which they receive cost reports, the items that require additional review, and the mechanism for rolling the data up to the Department cost report to be submitted to SC DHHS. PCG noted, however, that this knowledge was not documented but rather held by the staff responsible for the cost report process. The lack of clear policy and procedure documentation for all of the tasks required as part of the cost reporting process is a potential risk factor for the Department as external entities like SC DHHS have started to focus on the costs included in the cost reports and the rates generated from cost report data. While SC DDSN has taken steps to improve the documentation of the Department's practices regarding cost reports through the Department Directives, PCG recommends that SC DDSN develop a comprehensive policy and procedure document that describes all of the core functions and roles and responsibilities related to the cost reporting process. This document should at a minimum detail:

- Entities involved in the cost reporting process, i.e. SC DHHS, SC DDSN, DSN Boards, SC DDSN Regional Centers
- Roles and Responsibilities of each entity
- Instructions for completing the cost report
- SC DDSN audit procedures
- SC DDSN procedures for compiling the Department cost report

PCG believes that the development of a comprehensive cost reporting policy and procedure document will help to provide increased guidance to the providers required to complete the cost reports, provide increased transparency on the entire cost reporting process, and ensure the process is compliant with all state and federal regulations for cost reporting.

SC DDSN should move towards automating the Medicaid Cost Reporting Process

Given the highly manual process currently used for completing the Medicaid cost reporting for SC DDSN, PCG believes that there are efficiencies to be gained through an investment in the automation of the annual cost reports. Automated cost reports are a normal practice in states for

submitting cost report information. Through an automated cost reporting process, the DSN Boards would be able to complete and submit their cost reports through a web-based cost reporting system. SC DDSN would be able to leverage an automated solution to minimize manual review processes by developing custom edit checks within the system to identify possible cost report errors prior to the providers submitting the reports to the department. SC DDSN could also use the system to provide management reports that compares provider costs or that compile provider costs in a manner that allows for a more streamlined process to transfer the data to the Department cost report that is submitted to SC DHHS. In automating the cost reporting process, SC DDSN would also reduce the amount of time Department staff currently dedicates to the cost reporting process, allowing those staff to provide increased support and training to the providers in an effort to further reduce potential cost reporting errors.

Recommendations for SC DDSN Program Oversight Practices

PCG's review of the SC DDSN program oversight practices found many areas where the Department has taken great steps to improve upon their practices and specifically address items raised by outside entities like the LAC. The following recommendations have been developed to provide the Department with a set of items that can be used to further enhance their program oversight practices.

SC DDSN should separate service coordination and service delivery

SC DDSN should announce that conflict-free service coordination is an appropriate policy for the Department and begin discussions with stakeholders as to how best to implement this. A likely outcome of these conversations would be and should be a phased-in plan to have SC DDSN providers become either service coordination providers or service delivery providers. The separation of service coordination from service delivery was discussed at length in the 2008 LAC audit and PCG supports its recommendation that different entities should provide these services.

South Carolina has experience with this separation and the concept has been discussed for years. Additionally, the state has required new providers to choose to provide either service coordination or service delivery.

The LAC audit research shows that nearby states had this separation. This recommendation is also consistent with Federal Medicaid policy.

Section 10202 of the Affordable Care Act created the Balancing Incentive Program (BIP) in which states with higher institutional spending would receive a higher federal match if the balance of their funding shifted from institutional to home and community based services. One of the three requirements for states to participate was to have "conflict-free case management services" in their home and community-based programs.²⁸ As of August 2013, sixteen states had signed balancing incentive agreements with Medicaid.

²⁸ Affordable Care Act at 10202(c)(5)(B). See text of H.R. 3590 retrieved on 8-5-2013 from <http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>

In May 2012, CMS issued final regulations for the 1915(k) program Community First Choice. As promulgated in federal code, section 42 CFR 441.555(c) identifies who should not take part in the assessment. 42 CFR 441.555(c)(4) clearly states that "...assessments of functional need and the person-centered service plan development process..." shall not be done by "(4) Individuals who would benefit financially from the provision of assessed needs and services." As of August 2013, eleven states have approved 1915(k) programs.

In May 2013, CMS issued guidance for managed care organizations (MCOs) that are capitated for long-term services and supports. In a section titled "Individual Conflict-Free Choice Counseling and Independent Enrollment/Disenrollment", the guidance emphasizes the service delivery role of the MCO. "MCOs may not be involved in any eligibility determination or functional assessment processes for a potential participant prior to that participant enrolling in the MCO. Further, all MLTSS program enrollments must be processed through an independent, conflict-free entity."²⁹

Integral to this recommendation, is the implementation of the 2008 LAC recommendation that SC DDSN authorize existing providers to provide the same services in other parts of the state that they can provide in their own jurisdictions. Current restrictions on providers reduce the freedom of choice of persons seeking state services.

In 2014, CMS issued new rules for Home and Community Based Services.³⁰ These are broad sweeping rules which will impact multiple parts of state HCBS programs. Among other changes, these rules formalized the CMS emphasis on conflict free case management and required states to develop transition plans to bring their waivers into compliance with them. The prohibition on providers doing the assessment, developing the service plan, and providing the services has moved from policy guidance to what is now a federal requirement spanning all HCBS waiver programs and state plan authorities such as 1915(i).

In terms of planning for implementing the separation of service coordination from service delivery, SC DDSN might find it of use to discuss with Maine staff how that state went about its planning for its Independent HCBS DD/LTC Waiver Management Initiative.³¹

SC DDSN should consider annual licensing visit and changes in visit protocol

At the time of the 2008 LAC audit, SC DDSN programs were visited by licensing surveyors once every three years which was less frequently than the other four states that LAC studied. The 2008 audit recommended that annual licensing reviews be made. Since the 2008 report, SC DDSN

²⁹ See, retrieved on 8-2-2013 from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf> p. 10

³⁰ See <https://www.federalregister.gov/articles/2014/01/16> retrieved on 2-13-2014

³¹ See <http://www.stephengroupinc.com/pdfs/MECare-Redesign-Policy-Paper.pdf> Retrieved on 2-13-2014

changed its contracting practice and now currently contracts for biannual licensing reviews, that is, surveyors visit the homes every two years. SC DDSN also currently conducts annual licensing visits for day programs, respite and child residential settings.

PCG believes that the change from a three-year period to a two-year period was good and thinks that additional improvement can be achieved by moving to a one-year review period. All the states that the LAC reviewed performed annual reviews and PCG believes that customary state procedures are for annual reviews.

As a subsidiary recommendation, SC DDSN might consider requiring that provider management staff not be present during the surveyors' visit to the homes. The hovering presence of management staff potentially acts as an impediment to data collections and on-site observation.

SC DDSN should continue to educate stakeholders and prepare for changes in federal quality standards

PCG recommends that SC DDSN staff continue to monitor, educate stakeholders and acquaint itself with the potential federal changes in quality management and review what changes it might make in how quality management is presented in future 1915(c) waiver applications.

There are potentially significant changes coming in how quality is dealt with in 1915(c) applications for federal waivers. The Centers for Medicare and Medicaid Services (CMS) has worked with the National Association of Medicaid Directors (NAMC), the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the National Association of States United for Aging and Disabilities (NASUAD) along with 14 representatives from 10 states to review and evaluate the current Continuous Quality Improvement System process states must incorporate in their 1915(c) Home and Community-Based (HCBS) waiver applications. PCG notes that SC DDSN Director is a member of the National Board of Directors of NASDDDS which has helped keep SC DDSN abreast of upcoming national changes and trends. This effort is coming to fruition with a series of recommendation and will be released in the Fall of 2013 as a CMS informational bulletin.

These recommendations include the following changes to the 1915(c) assurances and sub-assurances:³²

In the level of care assurance, sub-assurance b. "The LOC of enrolled members is reevaluated at least annually or as specified in the approved waiver" will no longer be required. States, per statutory requirement will still be required to conduct annual reevaluations, but states will no longer be required to provide evidence that the reevaluations were done;

³² These descriptions are taken from CMS approved, but currently unpublished documents that are circulating among persons interested in 1915(c) quality matters.

In the service plan assurance, sub-assurance b. “The state monitors service plan development in accordance with its policies and procedures” will no longer be required. States must still develop service plans in accordance with their policies but will no longer have to present evidence that this is done.

In the service plan assurance, sub-assurance e. was changed to eliminate references to providing choices between institutional and waiver services. States still must provide choices but do not have to provide evidence that such choices were provided.

In the health and welfare assurance, four new sub-assurances were added to specify the general language in the assurance. This assurance must be accompanied by an aggregated report on individual remediation for substantiated instances of abuse, neglect and exploitation. Otherwise, CMS will consider that the assurance has not been met. CMS has proposed performance measures for each new sub-assurance.

In the financial accountability assurance, the assurance itself was rewritten and a new sub-assurance was added that evidence would be required to show that payments made would be in accordance with the reimbursement methodology specified in the waiver.

The administrative authority assurance and sub-assurances were unchanged but three performance measures are made explicit. The remediation reporting assurance was changed to only require reporting of abuse, neglect and exploitation, but CMS explicitly says states may be audited if performance falls below 86%. Since CMS requires a performance measure for each sub-assurance, a review of existing and new sub-assurances would be useful in determining what performance measures should continue to be reported; mindful that a score of less than 86% on any performance measure requires a Quality Improvement (QI) project.

These changes will take effect this Fall and can be implemented by amendments to current waivers or when waivers are renewed.

SC DDSN should implement a 1915(k) Community First Choice program

This recommendation encourages SC DDSN, in conjunction with SC DHHS, to take advantage of a 2012 final rule promulgated by CMS that implemented section 2401 of the Affordable Care Act, which added a new section, 1915(k), to the Social Security Act. On May 7, 2012, CMS promulgated a final rule for the Community First Choice program.³³ This final rule implements section 2401 of the Affordable Care Act, which added a new section, 1915(k), to the Social Security Act. The rule implemented the new State option which provides home and community-based attendant services and supports. These services and supports are known as Community First Choice (CFC). As of August 2013 eleven states have received approval from CMS to add this type

³³ See, retrieved on 8-4-2013 from <http://www.gpo.gov/fdsys/pkg/FR-2012-05-07/pdf/2012-10294.pdf>

of state plan amendment to their Medicaid program. Among states in the southeast, Arkansas and Louisiana have received permission to add this option to their Medicaid state plan.

The new state Medicaid plan option has considerable advantages to states that adopt it:

1. Adopting the program is fiscally conservative since a six percent higher federal Medicaid match is available for program expenditures. Federal policy behind the program is to expand home and community-based services and deemphasize institutional spending. It is not surprising that large states such as California and New York have enacted a CFC program since the savings to their intellectual and developmental disabilities programs are considerable. PCG has not projected the savings, but a maximum, rough ball-park estimate would be six percent of current waiver expenditures for persons served by SC DDSN.
2. Savings from implementing CFC can be used both to pay for its implementation and to reduce the waiting lists for SC DDSN services.
3. The CFC program encourages the use of self-direction and promotes the use of attendant care services. The self-direction service delivery model emphasized in the federal rules is a key component of the CFC program. Although SC DDSN has self-direction policies, few persons use them. With exceptions, South Carolina has traditional institutional policies that are not supportive of self-direction. The 2012-2013 National Core Indicator study contained a question reporting on the percentage of persons in a state that reported using a self-directed option. The study found that 3% of the respondents in South Carolina reported using a self-directed option and the study ranked South Carolina in the group of states that were “significantly below average.”
4. The CFC rules also provided States with the option to permanently waive the annual recertification requirement for individuals if it is determined that there is no reasonable expectation of improvement or significant change in the participant’s condition because of the severity of a chronic condition or the degree of impairment of functional capacity. This means that thousands of functional eligibility redeterminations that are done each year would no longer be necessary. The flexibility to waive this classic Medicaid requirement means substantial administrative savings each year and is one of the few administrative simplifications that CMS has provided states in recent years. The ability to waive this requirement is a federal acknowledgement that persons that have intellectual and developmental disabilities will continue to have them for the duration of their lives and the mindless requirement of annual determinations is unnecessary.
5. The CFC rules are helpful in controlling utilization under the new program since only persons that meet institutional level of care requirements are eligible for the program.

6. There is no loss of state flexibility since a state electing to use the CFC program can continue to offer all its current Medicaid waiver and state plan programs. Moreover, persons using CFC services can also receive waiver and other state plan services so administrative oversight and controls are not needed to ensure a person only used one program
7. For persons who are in institutions, the CFC program authorizes expenditures to help them leave the institution. For example, CFC covers expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities linked to an assessed need for an individual to transition from an institution such as a state regional center or an Intermediate Care Facility for persons with Intellectual and Developmental Disabilities (ICFs/IDDD).

SC DDSN should continue to review the National Core Indicators with providers and consumers

The National Core Indicator results are significant measurements of the experiences of program beneficiaries. The data are collected by an outside contractor and not filtered through the perceptions of provider staff. SC DDSN has a history of successfully engaging stakeholders in meaningful discussions on a range of topics including quality related data and would benefit from continued discussion with all stakeholders. SC DDSN has engaged provider organization with summary information and discussion of the NCI data. Inclusion of additional stakeholders would allow for a greater sense of ownership across all levels of the system while promoting transparency in the decision making of the Department.

SC DDSN has done an excellent job in other quality areas of promoting a widespread discussion of quality-related data and would benefit by implementing similar processes to discuss the core indicators. For example, a workgroup consisting of SC DDSN staff, provider representatives and consumers could be charged with reviewing the results and providing recommendations for changes in agency activities.

User experience surveys such as the National Core Indicators obtain feedback from individuals on their experience with a healthcare system and its providers. CMS currently uses experience surveys across multiple service delivery systems including hospitals, managed care organizations, home health services, and clinician groups, and is developing an experience survey for use with Medicaid waivers. Indicative of this emphasis, is the recent Federal Medicaid Planning and Demonstration Grant for Testing Experience and Functional Tools in Community-Based Long Term Services and Supports (TEFT).

CMS will distribute some \$40 million to states for four activities. One of these activities is the collection of data on a Consumer Experience Survey. This survey is designed to span all populations of persons using HCBS waiver programs. The survey is designed to be like surveys in the family of surveys known collectively as the Consumer Assessment of Healthcare Providers

and Systems (CAHPS)³⁴ The focus of these surveys is on the consumer's experience care, asking questions such as how did the doctor's office staff treat you and when you left the hospital did someone explain your medications to you.

The TEFT demonstration will collect thousands of interviews using the Consumer Experience Survey. At the end of the four-year demonstration, there is a probability that CMS will require its use by state Medicaid programs.

South Carolina has the opportunity to create a workgroup that can begin with the National Core Indicator results and systematically consider how consumers can improve their experience of care. Such a workgroup could consist of persons receiving services and their families, the quality contractor, e.g. Alliant or whoever holds the quality oversight contract currently, and state quality staff. The workgroup could study states that do well on the core indicator questions and recommend potential quality changes to promote meaningful residential, employment, and social experiences.

The workgroup could be a standing workgroup since it highly likely that CMS will require states to use consumer experience surveys and this group could provide planning leadership for responding to these changing federal requirements.

³⁴ See, retrieved on 11-3-2013 from <https://cahps.ahrq.gov/index.html>

VI. Appendices

Appendix A: Subject Matter of Recommendations made in 2008 Legislative Audit Council Review

Subject Matter of Recommendation	Count
add misdemeanor charge to statutes	1
Administrative	3
aging caregivers	1
auditing SC DDSN	2
caregiver criminal background checks	3
changes in how licensing is done	4
compliance with laws and rules	2
SC DDSN spending its budgeted funds	3
employee job referrals	3
encouraging new providers	8
expanding scope of current providers	1
financial	7
improvement of SC DDSN websites	2
money follows the person	1
need for follow up in quality assurance	4
private non-profit funding and payment equity	3
provider compliance with local zoning	1
separate service coordination from delivery	1
strengthening internal auditing	6
support and publicize pilot programs	2
training	3
use of "bands" in reimbursement	2
Total	63

Appendix B: South Carolina Department of Disabilities and Special Needs Critical Incident reporting

Report any of the following involving consumers:

- injuries requiring treatment (not required for steri-strips, derma-bond or less than 3 sutures);
- suicidal threats or gestures;
- staff cursing at consumers or using disrespectful language;
- any time LLE is involved and takes a report;
- contracting life threatening communicable disease;
- possession of weapons, knives, firearms or explosives;
- consumer elopement of one hour or more;
- possession of illegal substances;
- medical treatment not followed as prescribed;
- medication errors resulting in adverse reaction/poisoning
- criminal arrest;
- unplanned hospital admissions/3 overnight stays or more;
- major medical or other emergency medical procedures;
- admission to a Critical Care Unit, and
- date consumer meets 3 ER visits within 30 day period.

Report any of the following which occur involving staff only:

- Staff injury (requiring treatment) caused by consumer;
- Possession of illegal substances while on duty;
- Substance abuse while on duty, and
- Intentional reporting of services not provided/ not delivered.

Report any of the following that involve staff or consumers:

- Property damage/vandalism of \$2500.00 or more
- Vehicular accidents:
 - a) if injuries occur requiring treatment, submit Initial Report within 24 hours of Date of Incident.
 - b) if there are no injuries, wait until estimate for repair is received; if estimate meets or exceeds \$2500.00, meets criteria/Date of incident is date accident occurred; Discovery Date is date the estimate is received.

Report any of the following that involve facility or program operations:

- epidemic outbreaks;
- facility fires regardless of size;
- natural disasters;
- hazardous contamination in excess of \$2500.00;

- known or suspected misuse of agency funds;
- highly unusual incidents, and
- incidents of high public interest.

Source: Material taken from SC DDHS websites

See:

[http://ddsn.sc.gov/about/directives-standards/Documents/currentdirectives/100-09-DD%20-%20Revised%20\(092011\).pdf](http://ddsn.sc.gov/about/directives-standards/Documents/currentdirectives/100-09-DD%20-%20Revised%20(092011).pdf)

<http://www.ddsn.sc.gov/providers/qualitymgmt/Documents/Critical%20Incident%20Reporting%20Process-%20Training.pdf>